Please complete ALL information below and fax your request to 1-888-671-5285

Ninlaro® Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			**Provider Information** (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)		
Medication Name:	Strength:	Dosage Form:
❑ Check if **generic substitution** is acceptable ❑ Check if request is for **continuation of therapy**	Directions for Use:	

Clinical Information (required)

Select the diagnosis below:

❑ Multiple myeloma

❑ Other diagnosis: ____ ICD-10 Code(s): ____________________________________

Clinical Information:

Has the patient received at least one prior therapy for multiple myeloma (e.g., Revlimid [lenalidomide], Thalomid [thalidomide], Velcade [bortezomib])? ❑ **Yes** ❑ **No**

Will Ninlaro be used in combination with Revlimid (lenalidomide)? ❑ **Yes** ❑ **No**

Will Ninlaro be used in combination with dexamethasone? ❑ **Yes** ❑ **No**

Is Ninlaro prescribed by or in consultation with a hematologist/oncologist? ❑ **Yes** ❑ **No**

Reauthorization:

If this is a reauthorization request, answer the following question:

Does the patient show evidence of progressive disease while on Ninlaro therapy? ❑ **Yes** ❑ **No**

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

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Please note: This request may be denied unless all required information is received.

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