



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

### Temodar® (temozolomide) 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:
<input type="checkbox"/> Check if generic substitution is acceptable	Directions for Use:	
<input type="checkbox"/> Check if request is for continuation of therapy		

Clinical Information (required)	
<b>Select the diagnosis below:</b>	
<input type="checkbox"/> Newly diagnosed glioblastoma multiforme	
<input type="checkbox"/> Refractory anaplastic astrocytoma	
<input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____	
<b>Prescriber's Specialty:</b>	
Is Temodar (temozolomide) prescribed by or in consultation with an oncologist? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>For newly diagnosed glioblastoma multiforme, answer the following:</b>	
Is the patient's condition newly diagnosed? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Is the patient using Temodar (temozolomide) concomitantly with radiotherapy? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Will Temodar (temozolomide) be used as maintenance treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>For refractory anaplastic astrocytoma, answer the following:</b>	
Has the patient's condition progressed on a drug regimen containing a nitrosourea agent and procarbazine? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Reauthorization:</b>	
<b>If this is a reauthorization request, answer the following question:</b>	
Does the patient show evidence of progressive disease while on Temodar (temozolomide) therapy? <input type="checkbox"/> Yes <input type="checkbox"/> 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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