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:
❑ Check if **generic substitution** is acceptable ❑ Check if request is for **continuation of therapy**	Directions for Use:	

Clinical Information (required)

Select the diagnosis below:

❑ Newly diagnosed glioblastoma multiforme

❑ Refractory anaplastic astrocytoma

❑ Other diagnosis: _____ ICD-10 Code(s): _____

Prescriber's Specialty:

Is Temodar (temozolomide) prescribed by or in consultation with an oncologist? ❑ **Yes** ❑ **No**

For newly diagnosed glioblastoma multiforme, answer the following:

Is the patient's condition newly diagnosed? ❑ **Yes** ❑ **No**

Is the patient using Temodar (temozolomide) concomitantly with radiotherapy? ❑ **Yes** ❑ **No**

Will Temodar (temozolomide) be used as maintenance treatment? ❑ **Yes** ❑ **No**

For refractory anaplastic astrocytoma, answer the following:

Has the patient's condition progressed on a drug regimen containing a nitrosourea agent and procarbazine? ❑ **Yes** ❑ **No**

Reauthorization:

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

Does the patient show evidence of progressive disease while on Temodar (temozolomide) 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?

_____

_____

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