STATE OF WEST VIRGINIA
DEPARTMENT OF HEALTH AND HUMAN RESOURCES
BUREAU FOR MEDICAL SERVICES

Office of Pharmacy Service
Prior Authorization Criteria

Thalomid® (thalidomide)
Prior Authorization Request Form

Thalomid® shall be authorized for twelve (12) months when:

1) The member has a diagnosis of multiple myeloma that is newly diagnosed and is receiving concurrent dexamethasone; **OR**
2) The member has a diagnosis of severe erythema nodosum leprosum (ENL) with cutaneous manifestations

Provided that all of the following criteria have been met:

1) The member is twelve (12) years of age or older; **AND**
2) The member is not pregnant; **AND**
3) The prescriber is registered and the member is enrolled in the THALOMID REMS™ program; **AND**
4) The member will be monitored for signs and symptoms of venous thromboembolism (VTE); **AND**
5) The member will not use Thalomid® as monotherapy in the presence of moderate to severe neuritis.

Authorization for continued use shall be reviewed at least every twelve (12) months to confirm that the member has experienced an objective response to therapy.

References:
Thalomid® (package insert). Celgene; Summit, NJ February 2013

Reviewed and Approved
Drug Utilization Review Board
May 21, 2014