



Send completed form to:  
 Peach State Health Plan Pharmacy Department  
 Fax: 1-866-374-1579

## Temodar

### Prior Authorization Request

This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form toll-free to Peach State Health Plan at 1-866-374-1579.** If you have questions regarding the prior authorization, eligibility, drug copay or medication delivery; please contact Peach State Health Plan at 1-800-514-0083 option # 2.

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_  
 Patient's ID: \_\_\_\_\_ Patient's Date of Birth: \_\_\_\_\_  
 Physician's Name: \_\_\_\_\_  
 Specialty: \_\_\_\_\_ NPI#: \_\_\_\_\_  
 Physician Office Telephone: \_\_\_\_\_ Physician Office Fax: \_\_\_\_\_  
 Physician Office Address: \_\_\_\_\_

1. What drug is being prescribed?  Temodar  Other \_\_\_\_\_
2. What is the diagnosis?  Central nervous system (CNS) cancer  Other \_\_\_\_\_
3. What is CNS tumor type?  
 Glioblastoma multiforme  Anaplastic astrocytoma  Other \_\_\_\_\_
4. What is the ICD9? \_\_\_\_\_
5. Does the patient have a known hypersensitivity to dacarbazine?  Yes  No
6. Is the patient currently receiving Temodar therapy for CNS tumor type of either glioblastoma multiforme or anaplastic astrocytoma? *\*If yes, skip to #10*  Yes  No

*Complete the section designated below for the patient's CNS tumor type*

**Section A: Glioblastoma multiforme**

7. Is Temodar prescribed with radiotherapy for a newly diagnosed patient?  Yes  No
8. Is Temodar prescribed as maintenance treatment for glioblastoma multiforme?  Yes  No

**Section B: Anaplastic astrocytoma**

9. Has the patient experienced disease progression following nitrosourea and procarbazine therapy?  
 Yes  No

*Only answer question #10 if the patient is currently receiving Temodar*

10. Is the patient continuing to benefit from Temodar therapy?  Yes  No

**\*\*NOTE: We can NOT make a decision without documentation - Thank You\*\***

*Information given on this form is accurate as of this date:*

X \_\_\_\_\_  
**Prescriber or Authorized Signature** **Date (mm/dd/yy)**

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received the fax in error, please immediately notify the sender by telephone and destroy the original fax message. Temodar Centene - MD Fax 07/01/2011