P.O. Box 30192
Salt Lake City, UT 84120-0192
801-442-4912 or 800-442-3219
Fax 801-442-3006

selecthealth℠

PREAUTHORIZATION FORM

Folotyn™
(pralatrexate)

Therapeutic use: Treatment of relapsed or refractory peripheral T-cell lymphoma
Quantity Limit: 30 mg/m^2 administered IV once weekly for 6 weeks in 7-week cycles
Authorization Period: 12 months

Patient's name _____

Patient's ID# | | | | | | | | | | DOB | | | / | | | / | | | | |

ICD-9 | | | | | | | | | | | | _____

Physician's name_____

Physician's Ph# (| | |) | | | - | | | | | Fax# | | | - | | | | |

Physician's signature_____ Date signed | | / | | / | | | | |

Supervising Physician's name_____ (Required if requesting provider is a nurse practitioner or physician assistant)

Please check "Yes" or "No" and respond to the following requests:			
1.	Is the prescribing physician an oncologist?	❑ Yes	❑ No
2.	Does the patient have a diagnosis of peripheral T-cell lymphoma?	❑ Yes	❑ No
3.	Has the patient been treated with prior systemic therapy?	❑ Yes	❑ No

This form is intended for SelectHealth members only. All requests for preauthorization should be sent via fax to 1-801-442-3006. Missing, inaccurate, or incomplete information may cause a delay or denial of authorization.

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