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

PREAUTHORIZATION FORM

Velcade™
(bortezomib)

Therapeutic use: Treatment of multiple myeloma or mantle cell lymphoma after one prior therapy
Quantity Limit: Not to exceed eight 10ml vials (3.5mg per vial) per month
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 multiple myeloma?	❑ Yes	❑ No
3.	Does the patient have a diagnosis of mantle cell lymphoma?	❑ Yes	❑ No
3a.	If treating mantle cell lymphoma, has the patient failed or not tolerated an adequate trial of prior therapy (i.e. R-HyperCVAD, R-CHOP, R-EPOCH)?	❑ 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.

© 2010 SelectHealth. All rights reserved. 1306 02/10
Last Updated: February 24, 2010