PARAMOUNT
Affiliate of ProMedica

CRITERIA: STD
APPROVED: 2/2015
VERIFIED: 2/2021
REVIEWED:

Prior Authorization Criteria Form

This form applies to Paramount Commercial Members Only

Valchlor

Complete/review information, sign and date. Please fax signed forms to Paramount at **1-844-256-2025.** You may contact Paramount by phone at **1-419-887-2520** with questions regarding the Prior Authorization process. When conditions are met, we will authorize the coverage of Valchlor.

Brand Name (select from list of drugs shown)

Valchlor (mechlorethamine gel)

Quantity _____ Frequency _____ Strength_____
Route of Administration _____ Expected Length of Therapy _____

Patient Information

Patient Name: _____
Patient ID: _____
Patient Group No.: _____
Patient DOB: _____
Patient Phone: _____

Prescribing Physician

Physician Name: _____
Physician Phone: _____
Physician Fax: _____
Physician Address: _____
City, State, Zip: _____

Diagnosis: _____ ICD Code: _____

Comments: _____

Please circle the appropriate answer for each question.

1	Does the patient have a diagnosis of mycosis fungoides-type cutaneous T-cell lymphoma? [If yes, no further questions.]	Yes	No
2	Does the patient have a diagnosis of chronic or smoldering adult T-cell leukemia or lymphoma? [If yes, no further questions.]	Yes	No

3	Does the patient have a diagnosis of stage 2 or higher mycosis fungoides or Sezary syndrome? [If yes, no further questions.]	Yes	No
4	Does the patient have a diagnosis of primary cutaneous marginal zone lymphoma? [If yes, no further questions.]	Yes	No
5	Does the patient have a diagnosis of primary cutaneous follicle center lymphoma? [If yes, no further questions.]	Yes	No
6	Does the patient have a diagnosis of lymphomatoid papulosis?	Yes	No

I affirm that the information given on this form is true and accurate as of this date.

Prescriber (Or Authorized) Signature and Date