

Fax completed form to: 1-866-868-0858
Questions, please call: 1-866-316-6049



Important Information About Prescription Drug Coverage

To: _____ From: _____

Fax: _____ Pages: _____

Re: Revlimid® (lenalidomide): Prior Authorization Request Form: Please respond.

- Please complete the attached Revlimid® (lenalidomide) Prior Authorization Request Form
- To expedite the review process please complete all requested fields.
- Completed forms should be faxed to: 1-866-868-0858. It is not necessary to fax this cover page.

Please note: By signing the attached form you are certifying that the treatment requested is medically necessary. No contraindications are present and precautions have been considered. You will be supervising the patient's treatment. Supporting documentation is available in the patient's record. Signature on this form attests to the fact that the corresponding ICD-9 code has been documented in the patients chart and submitted on a CMS- 1500 form.

Information about this drug

Revlimid® (lenalidomide)

Revlimid® will be approved for FDA approved indications. Revlimid®'s use is limited by high rates of thrombocytopenia (61.5%), neutropenia (58.8%), diarrhea (48.6%), pruritis (41.9%), rash (35.8%), and fatigue (31.1%). As an analog of Thalomid® it may be associated with birth defects; females should be advised to avoid pregnancy and prescribers and pharmacists must be registered with REVASSIST®. In patients with multiple myeloma increased rates of DVT and PE were observed.

You can make an expedited request by indicating this at the top of the attached form. If you request an expedited review, and sign the attached form, you certify that applying the 72 hour standard review time frame may seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

Information on the attached form is protected health information and subject to all privacy and security regulations under HIPAA.

Prior Authorization Request Form



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Patient Information

Name _____
Member ID _____
Medicare ID _____
Date of birth _____ Sex: M / F
Address _____
City _____
State _____ ZIP _____
Phone _____
Nursing home resident? YES / NO
Home care patient? YES / NO

Prescriber and Pharmacy Information

Name _____
Specialty _____
DEA _____
NPI _____
Address _____
City _____
State _____ ZIP _____
Phone _____ Fax _____
Pharmacy name _____
NCPDP _____
NPI _____
Phone _____ Fax _____

All items below this line are for Physician Use Only

Information for Requested Drug

Strength: _____ Dosage form: _____ Qty per 30 days: _____ Drug is (circle one): Newly prescribed/Refill
Directions: _____ Diagnosis: _____ ICD-9 Code: _____

Standard Reviews will be completed in under 72 hours. An expedited review is available if you certify that a standard review timeframe will seriously jeopardize the health of your patient. To request an expedited review, simply indicate this at the top of this page.

Revlimid® (lenalidomide) Criteria

- Please indicate the patient's diagnosis. Select or specify the correct ICD-9 code. This question must be completed
 transfusion dependent anemia (requiring greater than or equal to 2 units of blood) due to low-or intermediate-1-risk plastic syndromes associated with a deletion 5q cytogenetic abnormality (ICD-9: 238.7)
 treatment of multiple myeloma in combination with dexamethasone in a patient who has failed at least one prior therapy (ICD-9:203)
 Other (ICD-9 and diagnosis): _____
- For the patient with multiple myeloma, does the patient meet any of the following criteria (please indicate)?
 SCr > 1.5mg/dL
 Transplant-eligible
 Prior history of DVT or PE
 Prior treatment history or exposure to thalidomide
 Baseline neutropenia (< or = 500cells/mm3)
 Not applicable
- Is the prescriber a hematologist/oncologist or has one been consulted?
 Yes No
- Does the patient have any of the following exclusion criteria to Revlimid® use? (check all that apply)
 Pregnancy
 Severe Thrombocytopenia (less than or equal to 50,000/ mm3)
 Severe Neutropenia (ANC greater than or equal to 500 cells/mm3)
 For new starts, ANC should exceed 500 cells/mm3 and platelets should exceed 50,000/mm3. Refill therapy should be interrupted or dose-adjusted to ANC and platelet counts as recommended in the manufacturer's guidelines.
- Can this patient understand and comply with contraceptive and pregnancy testing measures required in the RevAssist® program?
 Yes No
- Has patient failed to receive a clinically appropriate therapeutic response from other chemotherapeutic agents? Please list modalities trialed.

Medical Justification: (Attach additional page if necessary): _____

Prescriber's signature: _____ Date: _____