Pharmacy Prior Authorization Form

Fax completed form to: 877.974.4411 toll free, or 616.942.8206

This form applies to: ☒ **Commercial (Traditional)** ☒ **Commercial Individual (Optimized)** ☐ **Medicaid**

This request is: ☐ **Urgent** (life threatening) ☐ **Non-Urgent** (standard review)

Urgent means the standard review time may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.

Revlimid® (lenalidomide)

Member

Last Name: _____ First Name: _____

ID #: _____ DOB: _____ Gender: _____

Primary Care Physician: _____

Requesting Provider: _____ Prov. Phone: _____ Prov. Fax: _____

Provider Address: _____

Provider NPI: _____ Contact Name: _____

Provider Signature: _____ Date: _____

Product Information

Drug product: ☐ Revlimid 2.5 mg capsule ☐ Revlimid 15 mg capsule
☐ Revlimid 5 mg capsule ☐ Revlimid 20 mg capsule
☐ Revlimid 10 mg capsule ☐ Revlimid 25 mg capsule

Start date (or date of next dose): _____

Date of last dose (if applicable): _____

Dose: _____

Frequency: _____

Precertification Requirements

Before this drug is covered, the patient must meet all of the following requirements:

1. Diagnosis of myelodysplastic syndrome (MDS) with transfusion-dependent anemia; OR
2. Diagnosis of multiple myeloma (MM) ; OR
3. Diagnosis of relapsed or progressive Mantle cell lymphoma (MCL) following treatment with 2 prior therapies, including Velcade (bortezomib); OR
4. Diagnosis of previously treated marginal zone lymphoma, in combination with rituximab; OR
5. Diagnosis of previously treated follicular lymphoma, in combination with rituximab.

Note: Authorization for indications, dosing, or a route of administration not approved by the Food and Drug Administration (FDA) or recognized in CMS-accepted compendia (e.g. DrugDex, AHFS, U.S. Pharmacopeia, and also Clinical Pharmacology for oncology indications only) require supporting evidence for coverage. Please provide two published peer-reviewed literature articles supporting the appropriateness of the drug, the dosing of the drug, or the route of administration to be used for the identified indication.

Priority Health Precertification Documentation

A. What condition is this drug being requested for?

☐ Myelodysplastic syndrome (MDS)
☐ Multiple Myeloma (MM)
☐ Mantel cell lymphoma (MCL)
☐ Previously treated marginal zone lymphoma
☐ Previously treated follicular lymphoma
☐ *Other – the patient's condition is:* _____

Rationale for use: _____

All fields must be complete and legible for review. Your office will receive a response via fax.

No changes made since 09/2019
Last reviewed 09/2019

B. For myelodysplastic syndrome, does patient have transfusion-dependent anemia?

- ☐ Yes, *date of last transfusion*: _____
- ☐ No, *rationale:* _____

C. For Mantle cell lymphoma, please list previous treatments:

1. _____
2. _____
3. _____
4. _____
5. _____

D. For previously treated marginal zone lymphoma or follicular lymphoma, will the patient be using Revlimid in combination with rituximab?

- ☐ Yes
- ☐ No, *rationale:* _____

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