Please complete ALL information below and fax your request to 1-888-671-5285

Revlimid® Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:		Specialty:
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if **generic substitution** is acceptable ❑ Check if request is for **continuation of therapy**	Directions for Use:	

Clinical Information (required)

Select the diagnosis below:
- ❑ Mantle cell lymphoma (MCL)
- ❑ Multiple myeloma (MM)
- ❑ Myelodysplastic syndrome (MDS)
- ❑ Other diagnosis: ____ ICD-10 Code(s): ___________________________________

Provider's Specialty:
Is Revlimid prescribed by or in consultation with an oncologist/hematologist? ❑ **Yes** ❑ **No**

For mantle cell lymphoma (MCL), answer the following:
Does the patient have relapsed or progressed MCL? ❑ **Yes** ❑ **No**
Does the patient have history of failure, contraindication, or intolerance to two prior MCL therapies (e.g., bortezomib, bendamustine, cladribine, rituximab)? ❑ **Yes** ❑ **No**

For multiple myeloma (MM), answer the following:
Will Revlimid be used in combination with dexamethasone? ❑ **Yes** ❑ **No**
Will Revlimid be used as maintenance therapy following autologous hematopoietic stem cell transplantation (auto-HSCT)? ❑ **Yes** ❑ **No**

For myelodysplastic syndrome (MDS), answer the following:
Does the patient have symptomatic or transfusion-dependent anemia due to MDS? ❑ **Yes** ❑ **No**
Is the MDS associated with a deletion 5q abnormality? ❑ **Yes** ❑ **No**

Reauthorization:
If this is a reauthorization request, answer the following question:
Does the patient show evidence of progressive disease while on Revlimid therapy? ❑ **Yes** ❑ **No**

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

____

____

Please note: This request may be denied unless all required information is received.

This document and others if attached contain information that is privileged, confidential and/or may contain protected health information (PHI). The Provider named above is required to safeguard PHI by applicable law. The information in this document is for the sole use of FutureScripts. Proper consent to disclose PHI between these parties has been obtained. If you received this document by mistake, please know that sharing, copying, distributing or using information in this document is against the law. **If you are not the intended recipient, please notify the sender immediately.**

Office use only: Revlimid_FSP_2018Sep-W