

**PRIOR-AUTHORIZATION OF LENALIDOMIDE (REVLIMID™)**

**Maryland Pharmacy Program**

Tel#: 410-767-1455 or 1-800-492-5231 Option 3-Fax form to: 410-333-5398

**(Incomplete forms will be returned)**

**Patient Information**

Patient location: \_\_\_ Home; \_\_\_ Hospital \_\_\_ Clinic \_\_\_ Office Age: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Patient Name: \_\_\_\_\_

MA ID#: \_\_\_\_\_

Address: \_\_\_\_\_

Tel.#:(\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Has Patient received Red Blood Cell (RBC) transfusions in the past?  Yes  No

Is Patient currently receiving RBC transfusions?  Yes  No

Is Prescriber registered in the Rev Assist program?  Yes  No

List prior antimyeloma or MDS therapies: \_\_\_\_\_

Monthly lab tests are required for monitoring adverse effects and drug toxicity. Please provide most recent test results for:  
Platelet Count: \_\_\_\_\_/mcL Absolute Neutrophil Count (ANC) \_\_\_\_\_/mcL  
Test date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Date of last Office Visit: \_\_\_\_/\_\_\_\_/\_\_\_\_ Fax medical history summary when requesting initiation of therapy and for continuation of therapy, fax monthly platelet and ANC count to 410-333-5398.

**Prescriber Information**

Is Revlimid™ prescribed as part of a clinical study?  Yes  No

Specify sponsoring organization/drug manufacturer \_\_\_\_\_

Specify purpose of study: \_\_\_\_\_

Note: Off-label use or use of Revlimid™ at dosages or for indications other than recommended by FDA must be medically necessary and supported by the official compendia as mandated by CMS for use in determination of drug coverage for Medicaid Programs.

I certify that Patient is not enrolled in any study involving the requested drug. I will be supervising the patient's treatment accordingly. Supporting medical documentation is kept on file in the patient's medical record.

\_\_\_\_\_, M.D. Prescriber's Name: \_\_\_\_\_ Date: \_\_\_\_\_  
*(Prescriber's signature)*

Tel# (\_\_\_\_\_) - \_\_\_\_\_ - \_\_\_\_\_ Fax# (\_\_\_\_\_) - \_\_\_\_\_ - \_\_\_\_\_

License #: \_\_\_\_\_ NPI #: \_\_\_\_\_ Specialty : \_\_\_\_\_

Address: \_\_\_\_\_

**Prescription Information**

Drug/Strength/dosage prescribed: \_\_\_\_\_

List diagnosis for which the drug was prescribed:

Treatment of transfusion-dependent anemia due to Low-or Intermediate-1 risk myelodysplastic syndromes (MDS) associated with a deletion 5q cytogenetic abnormality with or without additional cytogenetic abnormalities.

MDS not related to 5 q deletion abnormality

Previously treated multiple myeloma

Multiple myeloma in combination with dexamethasone as first-line therapy

Chronic lymphoid leukemia

Other: \_\_\_\_\_

**FOR INTERNAL USE**

Approved:  Denied:  Date: \_\_\_\_\_ Reviewer's Initials \_\_\_\_\_

Reason for denial: \_\_\_\_\_