OptumRx has partnered with CoverMyMeds to receive prior authorization requests, saving you time and often delivering real-time determinations.
Visit go.covermymeds.com/OptumRx to begin using this free service.
Please note: All information below is required to process this request.
Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

Revlimid® Prior Authorization Request Form

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

Member Information (required)

Member Name:		
Insurance ID#:		
Date of Birth:		
Street Address:		
City:	State:	Zip:
Phone:		

Provider Information (required)

Provider Name:		
NPI#:	Specialty:	
Office Phone:		
Office Fax:		
Office Street Address:		
City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

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.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.