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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)	Provider Information (required)
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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:
<input type="checkbox"/> Check if requesting brand	Directions for Use:	
<input type="checkbox"/> 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.

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 OptumRx. 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_Comm_2018Sep-W