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 (Page 1 of 2)

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 requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

❑ Anemia due to myelodysplastic syndrome (MDS)
❑ Mantle cell lymphoma (MCL)
❑ Multiple myeloma (MM)
❑ Other diagnosis: ____ ICD-10 Code(s): ____________________________________

Clinical Information:

Is this request for continuation of prior Revlimid therapy? ❑ **Yes** ❑ **No**
Has the patient used Revlimid within the past 120 days? ❑ **Yes** ❑ **No**
Is Revlimid prescribed by or in consultation with an oncologist/hematologist? ❑ **Yes** ❑ **No**

For treatment of anemia due to myelodysplastic syndrome (MDS), also answer the following:

Does the patient have transfusion-dependent anemia? ❑ **Yes** ❑ **No**
Select the type of MDS that applies to the patient:
- ❑ MDS associated WITH a deletion 5q
  - ❑ Low- or intermediate-1-risk
- ❑ MDS WITHOUT a deletion 5q
  - ❑ Serum erythropoietin level is greater than 500 mU/mL
  - ❑ Serum erythropoietin level is less than or equal to 500 mU/mL
  - ❑ Patient has had trial and failure, contraindication, or intolerance to at least one erythropoietin agent [e.g., Aranesp (darboepoetin alfa), Epogen or Procrit (epoetin alfa)]

For mantle cell lymphoma (MCL), also answer the following:

Does the patient have relapsed, refractory, or progressed disease? ❑ **Yes** ❑ **No**
Has the patient had at least one prior mantle cell lymphoma therapy [e.g., Velcade (bortezomib), Treanda (bendamustine), cladribine, Rituxan (rituximab)]? ❑ **Yes** ❑ **No**

For multiple myeloma, also 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**

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Office use only: Revlimid_CMS_2019Jan-W

Revlimid® Prior Authorization Request Form (Page 2 of 2)

Quantity Limit:

What is the quantity requested per DAY? ______

What is the reason for exceeding the plan limitations?

- ❑ Titration or loading-dose purposes
- ❑ Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)
- ❑ Requested strength/dose is not commercially available
- ❑ There is a medically necessary justification why the patient cannot use a higher commercially available strength to achieve the same dosage and remain within the same dosing frequency. **Please specify**: ____
- ❑ Other: ____

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.
If the patient is not able to meet the above standard prior authorization requirements, please call 1-800-711-4555.
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.

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