



Revlimid (lenalidomide)

Prior Authorization Form Curascript Fax (888) 773-7386

Form with fields: Last Name, First Name, Prescriber's Name, Specialty, Home Phone, Work Phone, Office Phone, Office Fax, Home Address, City, State, ZIP, Address, City, State, ZIP, SCAN ID number, Date of Birth, Est. Start Date, Office Contact, For Specialty Medications Only: Shipping Address (if different from home address), Physician, Home, Special Instructions (i.e. Non-English Speaking Patient, etc.):

Medication: Diagnosis: Sig: Qty: Refills: ICD 9 Code:

Secondary/ Supplemental Insurance Company Phone Name of Insured ID Number Group Number

- 1. Is the initial prescription written or recommended by an Oncologist or Hematologist?
2. Is the patient diagnosed with myelodysplastic syndrome associated with deletion 5q cytogenetic abnormality (medullary blast count <=5% or macrocytic anemia) with or without additional chromosomal abnormalities?
3. Has the patient received blood transfusions of 2 or more units of red blood cells in the last 8 weeks and 2 or more units in the preceding 8 weeks?
4. Is the patient diagnosed with multiple myeloma?
5. Has the patient received at least one prior therapy with conventional chemotherapy?
6. Will the patient take this medication with dexamethasone?
7. Are there any other comments, diagnoses, symptoms, relevant lab values, and/or additional pertinent information that you feel is important to this review?

Physician's Signature: NPI/DEA #: Date:

For Internal Use Only: Approved, Denied, Reviewer's Initials, Decision Date, Comments