PRO ACT
PHARMACY BENEFIT MANAGEMENT

1230 US Highway 11
Gouverneur, NY 13642
Phone: 1-877-635-9545
Prior Authorization Fax: 1-844-712-8129

Revlimid® Prior Authorization Request Form (Page 1 of 2)

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:

❑ Mantel 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 mantel 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, bend amustine, 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**

1230 US Highway 11
Gouverneur, NY 13642
Phone: 1-877-635-9545
Prior Authorization Fax: 1-844-712-8129

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

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.

Please fax this form to 1-844-712-8129 to initiate a prior authorization review for the member and medication above.

Please note: plan benefits may limit or exclude coverage of specific medications including those requested on this form.

I certify, to the best of my knowledge, the statements and information provided on this form are factual and correct.

Provider/Representative (and Title): _____ **Date:** _____

PROACT INTERNAL USE ONLY:					
Clinical Review Decision					
	Approved, through				
	Denied (documentation attached, if necessary)				
Tracking:					
1st Attempt		2nd Attempt		Letter Mailed:	