OPTIMA HEALTH COMMUNITY CARE

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: ***The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request. All other information may be filled in by office staff; fax to 1-800-319-5003. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. Incomplete form will delay authorization process.***

Drug Requested: **Revlimid®** (lenalidomide)

***DRUG INFORMATON:* Complete below. Incomplete information will delay authorization process.**

Drug Form/Strength/Quantity: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ ***ICD Code, if applicable***: _____

***CLINICAL CRITERIA:* Complete below. Authorization process will be delayed if applicable boxes are not checked.**

- ❑ Prescriber is registered in the **REVLIMID REMS®** program.

AND

- ❑ Patient is being treated for transfusion-dependent anemia due to Low-or Intermediate-1-risk myelodysplastic syndromes associated with a deletion 5q cytogenetic abnormality with or without additional cytogenetic abnormalities.

OR

- ❑ Patient is being treated for multiple myeloma, in combination with dexamethasone

OR

- ❑ Mantle cell lymphoma (MCL) whose disease has relapsed or progressed after two prior therapies, one of which included bortezomib.

OR

- ❑ Multiple myeloma, as maintenance following autologous hematopoietic stem cell transplantation

Medication being provided by (check applicable box below):

❑ **Physician's office**

OR

❑ **Specialty Pharmacy*:*** ❑ **PropriumRx**

Use of samples to initiate therapy does not meet step-edit/preauthorization criteria.

Previous therapies will be verified through pharmacy paid claims or submitted chart notes.

Patient Name: _____

Member Optima #: _____ Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone #: _____ Fax #: _____

DEA OR NPI #: _____

REVISED/UPDATED: 7/26/2017