OPTUMRx®

Please note: All information below is required to process this request.
Mon-Fri: 6am to 6pm Eastern / Sat: 6am to 6pm Eastern

Optima Health

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)		
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:

❑ Mantle cell lymphoma (MCL)
❑ Multiple myeloma
❑ Myelodysplastic syndromes (MDS)
❑ Other diagnosis: ____ ICD-10 Code(s): ____________________________________

Clinical Information:
Is the prescriber registered in the Revlimid REMS program? ❑ **Yes** ❑ **No**

For mantle cell lymphoma (MCL), also answer the following:
Has the disease relapsed or progressed after two prior therapies, one of which included bortezomib (Velcade)? ❑ **Yes** ❑ **No**

For multiple myeloma, also answer the following:
Will Revlimid be used in combination with dexamethasone? ❑ **Yes** ❑ **No**

For myelodysplastic syndromes (MDS), also answer the following:
Does the patient have transfusion-dependent anemia due to low- or intermediate-1 risk myelodysplastic syndrome? ❑ **Yes** ❑ **No**
Does the patient have deletion 5q cytogenetic abnormality with or without additional cytogenetic abnormalities? ❑ **Yes** ❑ **No**

Medication being provided by: (Please check applicable box below)
❑ Physician's office ❑ ProprimumRx ❑ Specialty Pharmacy (specify name): ___________________________

****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.

Prescriber Signature: ____ **Date:** ____________________________________

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

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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.**
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