Revlimid (lenalidomide)
Prior Authorization Request Form

Caterpillar Prescription Drug Benefit
Phone: 877-228-7909 Fax: 800-424-7640

Instructions: Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the authorization request). Information contained in this form is Protected Health Information under HIPAA.

☐ **URGENT**

MEMBER INFORMATION	
LAST NAME:	**FIRST NAME:**
PHONE NUMBER:	**DATE OF BIRTH:**
STREET ADDRESS:	
CITY:	**STATE:** **ZIP CODE:**
PATIENT INSURANCE ID NUMBER:	

☐ **MALE** ☐ **FEMALE** **HEIGHT (IN/CM):** _____ **WEIGHT (LB/KG):** _____ **ALLERGIES:** _____

IF YOU ARE NOT THE PATIENT OR THE PRESCRIBER, YOU WILL NEED TO SUBMIT A PHI DISCLOSURE AUTHORIZATION FORM WITH THIS REQUEST WHICH CAN BE FOUND AT THE FOLLOWING LINK: PRIMETHERAPEUTICS.COM/NOPP

PATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE): _____
AUTHORIZED REPRESENTATIVE'S PHONE NUMBER: _____

PRESCRIBER INFORMATION	
LAST NAME:	**FIRST NAME:**
PRESCRIBER SPECIALTY:	**EMAIL ADDRESS:**
NPI NUMBER:	**DEA NUMBER:**
PHONE NUMBER:	**FAX NUMBER:**
STREET ADDRESS:	
CITY:	**STATE:** **ZIP CODE:**
REQUESTOR (if different than prescriber)**:**	**OFFICE CONTACT PERSON:**

MEDICATION OR MEDICAL DISPENSING INFORMATION			
MEDICATION NAME:			
DOSE/STRENGTH:	**FREQUENCY:**	**LENGTH OF THERAPY/REFILLS:**	**QUANTITY:**
☐ **NEW THERAPY** ☐ **RENEWAL** DURATION OF THERAPY (SPECIFIC DATES):		**IF RENEWAL:** DATE THERAPY INITIATED:	

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MEMBER'S LAST NAME: _____ **MEMBER'S FIRST NAME:** _____

1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION? ☐ YES (if yes, complete below) ☐ NO		
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE)**:**	**DURATION OF THERAPY** (SPECIFY DATES)**:**	**RESPONSE/REASON FOR FAILURE/ALLERGY:**

2. LIST DIAGNOSES:	**ICD-10:**
□ Cutaneous lupus □ Multiple myeloma (MM)/plasmacytoma □ Myelodysplastic syndromes (MDS) □ Primary systemic (light-chain) amyloidosis □ Diffuse large B-cell lymphoma(DLBCL) □ Other Diagnosis_____ICD-10 Code(s):_____	

3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.

For <u>all diagnoses</u>, answer the following:

Is the prescriber enrolled in the Revlimid REMS program? □ Yes □ No

Has the patient tried the generic lenalidomide product? □ Yes □ No

Does patient have an absolute contraindication to the generic lenalidomide? □ Yes □ No **Please provide supporting chart notes.*

If the patient has tried the authorized generic lenalidomide and will not be continuing it, has a U.S. FDA MedWatch Voluntary Reporting Form for adverse drug reactions (FDA Form 3500) been filed with the FDA? □ Yes □ No *Please submit a copy of the completed FDA 3500 form*.

For <u>cutaneous lupus</u>, also answer the following:
Does the patient have panniculitis? □ Yes □ No

Has the patient failed an anti-malarial such as hydroxychloroquine, chloroquine, or quinacrine? □ Yes □ No

Has the patient failed a second-line systemic agent, such as (but not limited to) thalidomide, systemic corticosteroids, methotrexate, acitretin, azathioprine, or mycophenolate mofetil? □ Yes □ No

Is the prescriber a dermatologist? □ Yes □ No

For <u>multiple myeloma (MM)/plasmacytoma</u>, also answer the following:
Does the patient have an absolute neutrophil count (ANC) of at least 500 cells/mm3? □ Yes □ No

Does the patient have a platelet count of at least 30,000/mm3?□ Yes □ No

Did the patient have a stem cell transplant? □ Yes □ No

For <u>myelodysplastic syndromes (MDS),</u> also answer the following:
Does the patient have del (5q) chromosomal abnormalities? □ Yes □ No

Does the patient have transfusion-dependent anemia? □ Yes □ No

Has the patient had two or more units of red blood cells in the previous 8 weeks? □ Yes □ No

For <u>primary systemic (light-chain) amyloidosis</u>, also answer the following:
Does the patient have an absolute neutrophil count (ANC) of at least 1,000 cells/mm3? □ Yes □ No

Does the patient have a platelet count of at least 75,000/mm3? □ Yes □ No

<u>For Diffuse Large B-Cell Lymphoma(DLBCL),</u> also answer the following:
Does patient have relapsed and/or refractory disease? □ Yes □ No

Has patient received at least one, but no more than three previous systemic therapies for the treatment of DLBCL? □ Yes □ No *Please submit chart documentation.*

Is one of the prior therapies a CD20-targeted therapy such as rituximab(Rituxan) or Obinutuzumab(Gazyva)? □ Yes □ No *Please submit chart documentation.*

Does patient have an ECOG group 0 to 2? □ Yes □ No

Does patient have any other type of lymphoma? □ Yes □ No

Does patient have primary refractory DLBCL? □ Yes □ No

Does patient have a history of mutations in the MYC, BCL2, and/or BCL6 gene(s)? □ Yes □ No *Please submit chart documentation.*

Has patient been previously treated with lenalidomide or thalidomide? □ Yes □ No *Please submit chart documentation.*

Has patient undergone previous allogenic stem cell transplant? □ Yes □ No

Does patient does have CNS lymphoma? □ Yes □ No

Is patient going to use lenalidomide in combination with Monjuvi(tafasitamab)? □ Yes □ No

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: Not all drugs/diagnosis are covered on all plans. This request may be denied unless all required information is received.

ATTESTATION: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature or Electronic I.D. Verification: _____ Date: _____

FAX THIS FORM TO: 800-424-7640
MAIL REQUESTS TO: Prime Therapeutics Management Prior Authorization Program
Attn: CP-4201
P.O. Box 64811
St Paul, MN 55164-0811
Phone: 877-228-7909