PRIOR-AUTHORIZATION OF LENALIDOMIDE (REVLIMID™)
Maryland Pharmacy Program
Tel#: 410-767-1455 or 1-800-492-5231 Option 3-Fax form to: 410-333-5398
(**Incomplete forms will be returned**)

Patient Information

Patient location: ____ Home; ____ Hospital___ Clinic___Office Age: _____ Date of Birth:_____/_____/_____
Patient Name:_____
MA ID#:_____ Address: _____
Tel.#:(_____) _____-_____ _____
Has Patient received Red Blood Cell (RBC) transfusions in the past? □ Yes □ No
Is Patient currently receiving RBC transfusions? □ Yes □ No
Is Prescriber registered in the Rev Assist program? □ Yes □ No
List prior antimyeloma or MDS therapies:_____
_____
Monthly lab tests are required for monitoring adverse effects and drug toxicity. Please provide most recent test results for:
Platelet Count: _____/mcL Absolute Neutrophil Count (ANC) _____/mcL
Test date: _____/_____/_____ Date of last Office Visit:_____/_____/_____Fax medical history summary when requesting initiation of therapy and for continuation of therapy, fax monthly platelet and ANC count to 410-333-5398.

Prescriber Information

Is Revlimid™ prescribed as part of a clinical study? □ Yes □ No
Specify sponsoring organization/drug manufacturer_____
Specify purpose of study: _____

Note: Off-label use or use of Revlimid™ at dosages or for indications other than recommended by FDA must be medically necessary and supported by the official compendia as mandated by CMS for use in determination of drug coverage for Medicaid Programs**.**

I certify that Patient is not enrolled in any study involving the requested drug. I will be supervising the patient's treatment accordingly. Supporting medical documentation is kept on file in the patient's medical record.

_____, M.D. Prescriber's Name: _____ Date: _____
(Prescriber's signature)
Tel# (_____) – _____- _____Fax# (_____) - _____ - _____
License #: _____NPI #:_____ Specialty : _____
Address: _____

Prescription Information

Drug/Strength/dosage prescribed: _____
List diagnosis for which the drug was prescribed:
- □ Treatment of transfusion-dependent anemia due to Low-or Intermediate-1 risk myelodysplastic syndromes (MDS) associated with a deletion 5q cytogenetic abnormality with or without additional cytogenetic abnormalities.
  - □ MDS not related to 5 q deletion abnormality
- □ Previously treated multiple myeloma
- □ Multiple myeloma in combination with dexamethasone as first-line therapy
- □ Chronic lymphoid leukemia
- □ Other: _____

FOR INTERNAL USE

Approved: □ Denied: □ Date: _____Reviewer's Initials_____
Reason for denial: _____