CareFirst
The CareFirst BlueCross BlueShield family of health care plans

Revlimid® – Prior Authorization Request (For Maryland Only)

Send completed form to: Case Review Unit CVS/caremark Specialty Programs Fax: 866-249-6155

CVS/caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS/caremark toll-free at 866-249-6155**. If you have questions regarding the prior authorization, please contact CVS/caremark at **866-814-5506.** For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 800-237-2767.

Patient Name:	**Date**:
Patient's ID:	**Patient's Date of Birth:**
Physician's Name:	
Specialty:	**NPI#:**
Physician Office Telephone:	**Physician Office Fax:**

1. What drug is being prescribed? ☐ Revlimid® ☐ Other _____

2. What is the diagnosis?
   - ☐ Systemic light chain amyloidosis
   - ☐ Chronic lymphocytic leukemia (CLL)/ small lymphocytic lymphoma (SLL)
   - ☐ Non-Hodgkin's lymphoma (NHL)
   - ☐ Myeloma or progressive solitary plasmacytoma
   - ☐ Myelodysplastic syndrome (MDS)
   - ☐ Other _____

3. What is the ICD code? _____

4. What is the patient's weight? _____ ***provide units***

5. Would the prescriber like to request an override of the step therapy requirement? ☐ Yes ☐ No If no, skip to #8.

6. Has the member received the medication through a pharmacy or medical benefit within the past 180 days? ☐ Yes ☐ No
   ACTION REQUIRED: Please provide documentation to substantiate the member had a prescription paid for within the past 180 days (i.e., PBM medication history, pharmacy receipt, EOB etc.)

7. Is the medication effective in treating the member's condition? ☐ Yes ☐ No
   Continue to #8 and complete this form in its entirety.

8. How will Revlimid be used?
   - ☐ As monotherapy / Single agent
   - ☐ In combination with dexamethasone
   - ☐ Other _____
   - ☐ In combination with rituximab (Rituxan☐)
   - ☐ In combination with prednisone **and** melphalan

Complete the following section based on patient's diagnosis if applicable

<u>Section A: Non-Hodgkin's Lymphoma (NHL)</u>

9. Does the patient have one of the NHL diagnoses?
   - ☐ AIDS-related diffuse large B-cell lymphoma
   - ☐ AIDS-related lymphoma associated with Castleman's disease
   - ☐ AIDS-related primary effusion lymphoma
   - ☐ Diffuse large B-cell lymphoma
   - ☐ Follicular lymphoma
   - ☐ Gastric mucosa associated lymphoid tissue (MALT) lymphoma
   - ☐ Mantle cell lymphoma
   - ☐ Nodal marginal zone lymphoma
   - ☐ Nongastric MALT lymphoma
   - ☐ Primary cutaneous B-cell lymphoma
   - ☐ Splenic marginal zone lymphoma
   - ☐ Other _____

10. Is the disease relapsed, refractory, or progressive? ☐ Yes ☐ No

<u>Section B: Myeloma or Progressive Solitary Plasmacytoma</u>

11. What is the intent of treatment? ☐ Primary therapy ☐ Maintenance therapy ☐ Salvage or palliative use

Section C: Myelodysplastic Syndrome (MDS)

12. Is MDS low or intermediate-1 (INT-1) risk? ☐ Yes ☐ No
13. Is the patient currently receiving/has received previous therapy with Revlimid® for MDS?
    If Yes, no further questions ☐ Yes ☐ No
14. Does the patient have 5q deletion cytogenetic abnormality? ***Action Required: Attach results of genetic testing***
    ☐ Yes ☐ No ☐ Test not performed *If No, skip to #12*
15. Does the patient have transfusion-dependent anemia (i.e., required greater than or equal to 2 units of RBCs in previous 8 weeks)? *If Yes, no further questions* ☐ Yes ☐ No
16. Does the patient have symptomatic anemia? ☐ Yes ☐ No
17. What is the patient's **PRE-TREATMENT** sEpo level? _____ mU/mL ☐ Unknown
18. Has the anemia failed to respond to epoetin (Epogen® or Procrit®) **OR** darbepoetin (Aranesp®)? ☐ Yes ☐ No

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS/caremark or the benefit plan sponsor.

X_____

Prescriber or Authorized Signature **Date: (mm/dd/yy)**