

Date of Request: _____

Sterling Retiree Rx Prior Authorization Form

REVLIMID (Lenalidomide)

Coverage Criteria / Required Medical Information

Diffuse Large B-cell Lymphoma: relapsed, refractory or progressive disease.

Mantle Cell Lymphoma: as monotherapy for relapsed, refractory or progressive disease.

Systemic Light Chain Amyloidosis: use as primary treatment in combination with dexamethasone.

Myeloma: FDA approved uses **or** palliative treatment **or** primary induction in combination with dexamethasone **or** maintenance therapy as monotherapy after stem cell transplant **or** in responders to primary induction therapy.

Low or Intermediate-1 Risk MDS: for those with 5q deletion, patients should have transfusion dependent anemia **or** clinically significant cytopenias and symptomatic anemia. For those with non-5q deletion and symptomatic anemia, patients should have failed to respond to epoetin alfa or darbepoetin **or** have serum erythropoietin levels greater than 500 mU/mL and a low probability of response to immunosuppressive therapy.

Male and female patients of child-bearing potential should be instructed on the importance of proper utilization of appropriate contraceptive methods for Revlimid use. Patients should be monitored for signs and symptoms of thromboembolism.

Exclusion Criteria

Pregnancy

Member Information

Name					
Enrollment/Card-holder ID Number					
Group/Plan		Male		Female	
Date of Birth		Age		Weight in Kg	
Street Address					
City		State		Zip	

Physicians Information

Name					
Agent		Contact Name			
Specialty/Office					
Clinic Name					
Street Address					
City		State		Zip	
Phone		Fax			



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Requested Drug			
REVLIMID	Reason for Request		
Condition/Diagnosis Related			
Clinical Drug/Lab History Pertinent to Request			
Labs: Baseline/Ongoing		Strength/Dosage	
Formulary Alternative(s) Attempted?	Yes:		No: <input type="checkbox"/>
Please List Alternative Formulary Drugs			
Comments			

Physicians Signature: _____ Fax Form to 1-866-481-3704