HEALTHTRANS

Prior Authorization Request

Date of Request ________________

Revlimid

Revlimid (Lenalidomide) is an immunomodulatory agent with anti-angiogenic and anti-neoplastic properties indicated for the treatment of:

1. Transfusion-dependent anemia due to low- or intermediate- 1-risk myelodysplastic syndrome
2. Multiple myeloma in combination with dexamethasone in patients who have received at least one prior therapy

A thalidomide analogue, it has special restricted distribution through "RevAssist" program.

Enrollment / Cardholder ID ________________

Group / Plan ________________

Birth date ________________

Address: ________________

City State Zip ________________

Gender (Circle)

Male **Female**

AGE: ________ **Weight (kg):** ________

Practitioner Information

Name ________________

Agent / Contact Name ________________

Specialty ________________

Office / Clinic Name ________________

Address ________________

City State Zip ________________

Phone (   )   -

Fax (   )   -

ID Number ________________

Email ________@________

Notes:

Requested Drug / Pharmaceutical

Revlimid (Lenalidomide)

Strength / Dose

Therapy Start Date

Condition / Diagnosis Related - Reason for Request

Duration of Therapy (Expected)

Type of Request (Circle)

One-Time On-Going

Clinical Drug / Lab History Pertinent to Request

Labs: **Baseline / Ongoing**

Formulary Alternative(s) Attempted **YES** **NO** (Circle)

Please List:

Contact Pharmacy? Y N

Pharmacy Phone Number

____
Practitioner Signature

Date Received:
Reviewed By:
Forwarded To:

FAX Form to:
877-800-5633

HT Clinical Services Phone
866-805-1690