



**Prescription Drug Coverage Determination Form**  
Immune modulator  
Revlimid® (lenalidomide)

Please fax the completed form to Mercy Health Plans' Pharmacy Department  
at 314-214-8201 or 1-800-466-9854.

**Patient Information**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Subscriber ID#: \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

**Physician Information**

Name: \_\_\_\_\_ Specialty: \_\_\_\_\_ Tax ID#: \_\_\_\_\_  
Office Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_ Contact Person \_\_\_\_\_

Physician Signature (REQUIRED): \_\_\_\_\_ Date \_\_\_\_\_

Medication Information (requests for non-formulary agents will be considered for members having a documented failure or contraindication to preferred agents.)

Medication name: \_\_\_\_\_ J-code: \_\_\_\_\_  
Dose: \_\_\_\_\_ Directions: \_\_\_\_\_  
Expected Duration of Therapy: \_\_\_\_\_

**Prior Authorization Criteria:**

- |  |                              |                             |
|--|------------------------------|-----------------------------|
| 1. Is the medication being requested to treat an FDA-approved indication not otherwise excluded from Part D?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Diagnosis: _____ ICD-9 code _____  |                              |                             |
| 2. Does the patient have a diagnosis of multiple myeloma?  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| If yes:  |                              |                             |
| ▪ Will Revlimid® be used in combination with dexamethasone?  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| ▪ Has the patient tried at least one prior multiple myeloma treatment?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3. Does the patient have a diagnosis myelodysplastic syndrome associated-anemia (e.g. hemoglobin $\leq$ 10 mg/dL)?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| If yes:  |                              |                             |
| ▪ Is the patient "transfusion-dependent" (e.g. patient has required $\geq$ 2 units of red blood cells in the prior 8 weeks)?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| ▪ Is the anemia of the patient due to Low- or Intermediate-1-risk (International Prognostic Scoring System [IPSS] score of 0, 0.5, or 1.0) myelodysplastic syndrome? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

<ul style="list-style-type: none"> <li>▪ Is the myelodysplastic syndrome associated with a deletion of 5q cytogenetic abnormality?</li> </ul>	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Is the patient a female of childbearing potential? If yes: <ul style="list-style-type: none"> <li>▪ Has pregnancy been excluded by 2 negative urine or serum pregnancy tests?</li> </ul>	<input type="checkbox"/> Yes <input type="checkbox"/> No  <input type="checkbox"/> Yes <input type="checkbox"/> No
6. Has the patient been instructed on the importance and proper utilization of appropriate contraceptive methods?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Please provide any additional history or medical information that may support coverage (attach office notes as necessary): \_\_\_\_\_

Note: If approved coverage will be as specified in above criteria or through the end of the year (December 31, 20xx). Some medications may be subject to quantity limitations or restricted to certain pharmacies.