



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 1-800-647-2240.

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. 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 |
| 2. Does the patient have a diagnosis of 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 |
| ▪ Is the myelodysplastic syndrome associated with a deletion of 5q cytogenetic abnormality? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3. Will the complete blood count (CBC) of the patient be monitored weekly for the first eight weeks and at least monthly thereafter? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

4. Is the patient a female of childbearing potential?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes:		
▪ Has pregnancy been excluded by 2 negative urine or serum pregnancy tests?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
5. 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.