US Family Health Plan
Prior Authorization Request Form for
lenalidomide **(Revlimid)**

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD.

The completed form may be **faxed** to **855-273-5735**

OR

The patient may attach the completed form to the prescription and **mail** it to:
Attn: Pharmacy, 77 Warren St, Brighton, MA 02135

QUESTIONS? **Call 1-877-880-7007**

usfamilyhealth.org/rx-pa

Step 1 **Please complete patient and physician information** (please print):

Patient Name:		Physician Name:	
Address:		Address:	
Sponsor ID #		Phone #:	
Date of Birth:		Secure Fax #:	

Step 2 **Please complete the clinical assessment:**

1. Is the patient GREATER THAN or EQUAL to 18 years of age?	☐ Yes Proceed to question **2**	☐ No **STOP** **Coverage not approved**
2. Is the requested medication being prescribed by or in consultation with a hematologist or oncologist?	☐ Yes Proceed to question **3**	☐ No **STOP** **Coverage not approved**
3. For which indication is the requested medication being prescribed?	☐ Mantle cell lymphoma (MCL) – proceed to question **4** ☐ Multiple myeloma – proceed to question **12** ☐ Myelodysplastic syndrome w/5q deletion – proceed to question **5** ☐ Relapsed/refractory multi-centric Castleman's Disease – proceed to question **6** ☐ Diffuse large B-cell lymphoma (Non-Hodgkin Lymphoma) – proceed to question **7** ☐ Previously treated follicular lymphoma – proceed to question **8** ☐ Previously treated marginal zone lymphoma – proceed to question **8** ☐ Relapsed/refractory classical Hodgkin's lymphoma – proceed to question **12** ☐ Myelofibrosis - proceed to question **9** ☐ Systemic light chain amyloidosis with organ involvement – proceed to **12** ☐ Other - proceed to question - **10**	

4. Has the MCL been refractory to at least 2 prior treatment regimens, one of which contains bortezomib (Velcade) OR at least 1 prior treatment regimen and has failed or has a contraindication to bortezomib?	☐ Yes Proceed to question **12**	☐ No **STOP** **Coverage not approved**
5. Does the patient have one or more of the following: ○ **symptomatic anemia,** ○ **transfusion-dependent anemia, or** ○ **anemia not controlled with an erythroid stimulating agent?**	☐ Yes Proceed to question **12**	☐ No **STOP** **Coverage not approved**
6. Has the patient's condition responded to non-lenalidomide management?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **12**
7. Is the requested medication being used as second-line (or subsequent) therapy relapsed/refractory to non-lenalidomide management?	☐ Yes Proceed to question **12**	☐ No **STOP** **Coverage not approved**
8. Will the requested medication be used in combination with a rituximab product?	☐ Yes Proceed to question **12**	☐ No **STOP** **Coverage not approved**
9. Is the patient's condition refractory to or does the patient have contraindications to alternative therapies?	☐ Yes Proceed to question **12**	☐ No **STOP** **Coverage not approved**
10. Please provide the diagnosis.	_____ Proceed to question **11**	
11. Is the diagnosis cited in the National Comprehensive Cancer Network (NCCN) guidelines as a category 1, 2A, or 2B recommendation?	☐ Yes Proceed to question **12**	☐ No **STOP** **Coverage not approved**
12. Will the patient be taking the requested medication concurrently with pomalidomide (Pomalyst) or thalidomide (Thalomid)?	☐ Yes **STOP** **Coverage not approved**	☐ No **Proceed to question 13**
13. Is the prescriber certified through the Revlimid REMS program?	☐ Yes Proceed to question **14**	☐ No **STOP** **Coverage not approved**

14. Is the provider aware and has informed the patient of risk of serious, life-threatening, and fatal: cytopenias; angioedema; cutaneous reactions, including drug rash with eosinophilia and systemic symptoms (DRESS) and Stevens Johnson Syndrome spectrum reactions – including toxic epidermal necrolysis; VTE; risk of secondary malignancy; risk of increased mortality in certain disease states; hepatotoxicity, tumor lysis syndrome and tumor flare reaction; impaired stem cell mobilization; and thyroid disorders?	☐ Yes Proceed to question **15**	☐ No **STOP** **Coverage not approved**
15. Is the patient of reproductive age?	☐ Yes Proceed to question **16**	☐ No Proceed to question **17**
16. Will the patients (males and females) of reproductive potential use effective contraception during treatment and for at least 4 weeks after discontinuation?	☐ Yes Proceed to question **17**	☐ No **STOP** **Coverage not approved**
17. What is the patient's gender?	☐ Male **Sign and date below**	☐ Female Proceed to question **18**
18. Is the patient pregnant or planning to become pregnant?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **19**
19. Will the patient breastfeed during treatment?	☐ Yes **STOP** **Coverage not approved**	☐ No **Sign and date below**

Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date:

Prescriber Signature _____ Date _____