Revlimid® (lenalidomide) Prior Authorization Form

Incomplete forms will not be reviewed.

Maryland Medicaid Pharmacy Program
Fax: (410) 333-5398
Phone: (833) 325-0105

Date: _____

Patient Information

Name: _____ DOB: _____

Medicaid Assistance Number: _____ ❑ M ❑ F Height: _____ Weight: _____

Prescriber Information

Name: _____ NPI: _____

Contact Person for this Request:

Name: _____ Phone: _____ Fax: _____

Diagnosis

❑ Multiple myeloma, in combination with dexamethasone

❑ Multiple myeloma, maintenance therapy following autologous hematopoietic stem cell transplantation

❑ Myelodysplastic syndrome, transfusion-dependent anemia in patients at low-or intermediate-1 risk with deletion 5q abnormality

❑ Mantle cell lymphoma, relapse, or progression after two prior therapies, one of which included bortezomib

❑ Follicular lymphoma, previously treated, in combination with rituximab

❑ Marginal zone lymphoma, previously treated, in combination with rituximab

❑ Other: _____

Prescription Information

Strength: Revlimid® (lenalidomide) capsule: _____ mg

Directions: _____

❑ Submit most recent progress note for both initial and renewal requests. Objective clinical benefits should be evident in the note for any renewal request.

I attest that

❑ Patient's lab/test results and clinical data will be evaluated and monitored.

❑ The requested medication is not part of a clinical trial and that the benefits of the treatment outweigh the risks and verify that the information provided on this form is true and accurate to the best of my knowledge.

MDH and prescriber acknowledge and agree that this request may be executed by electronic signature, which shall be considered as an original signature for all purposes and shall have the same force and effect as an original signature.

Prescriber's Signature_____ Date_____