BlueCross BlueShield
Federal Employee Program

REVLIMID
PRIOR APPROVAL REQUEST

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

Patient Information (required)			Provider Information (required)		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: R			Physician Signature:		
PHYSICIAN COMPLETES					

Revlimid (lenalidomide)

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

NOTE: Form must be completed in its **entirety** for processing

Is this request for brand or generic? ❑Brand ❑Generic

What is the patient's total daily dose (mg per day) of Revlimid? _____ mg per day

1. What is the patient's diagnosis?

❑Classical Hodgkin lymphoma
- a. Has the patient been on Revlimid continuously for the last **6 months**, excluding samples? ❑Yes ❑No*
  If NO, are the prescriber and the patient certified with the Lenalidomide REMS program? ❑Yes ❑No

❑Multiple Myeloma (MM)
- a. Has the patient been on Revlimid continuously for the last **6 months**, excluding samples? ❑Yes ❑No*
  If NO, please answer the following questions:
  - i. Will Revlimid be used in combination with dexamethasone or another corticosteroid? ❑Yes ❑No
  - ii. Is Revlimid being used as maintenance following autologous hematopoietic stem cell transplantation (auto-HSCT)? ❑Yes ❑No
  - iii. Are the prescriber and the patient certified with the Lenalidomide REMS program? ❑Yes ❑No

❑Myelodysplastic Syndrome (MDS)
- a. Has the patient been on Revlimid continuously for the last **6 months**, excluding samples? ❑Yes ❑No*
  If NO, please answer the following questions:
  - i. Does the patient have low or intermediate -1 risk myelodysplastic syndromes? ❑Yes ❑No
  - ii. Does the patient have transfusion-dependent anemia? ❑Yes ❑No
  - iii. Are the prescriber and the patient certified with the Lenalidomide REMS program? ❑Yes ❑No

❑Non-Hodgkin Lymphoma (NHL)
- a. What is the specific histology, or specific type, of the non-Hodgkin lymphoma? ***Please select answer below:***

❑AIDS-related diffuse large B-cell lymphoma
❑Castleman's disease
❑Chronic lymphocytic leukemia (CLL)
❑Diffuse large B-cell lymphoma
❑Follicular cell lymphoma
❑Mantle cell lymphoma (MCL)
❑Marginal zone lymphoma
❑Primary cutaneous B-cell lymphoma
❑Primary effusion lymphoma
❑Small lymphocytic lymphoma (SLL)
❑Nongastric/Gastric mucosa associated lymphoid tissue (MALT) lymphoma
❑Other ***(please specify)***: _____

- b. Is the patient's disease relapsed, refractory, or progressive? ❑Yes ❑No
- c. Has the patient been on Revlimid continuously for the last **6 months**, excluding samples? ❑Yes ❑No*
  If NO, are the prescriber and the patient certified with the Lenalidomide REMS program? ❑Yes ❑No

❑Systemic light chain amyloidosis
- a. Has the patient been on Revlimid continuously for the last **6 months**, excluding samples? ❑Yes ❑No*
  If NO, are the prescriber and the patient certified with the Lenalidomide REMS program? ❑Yes ❑No

❑Other diagnosis ***(please specify)***: _____

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Message:

Attached is a Prior Authorization request form.

For your convenience, there are 3 ways to complete a Prior Authorization request:

Electronically Online (ePA) Results in 2-3 **minutes** **FASTEST AND EASIEST**	Now you can get responses to drug Prior Authorization requests **securely** online. **Online** submissions may receive **instant** responses and do not require faxing or phone calls. Requests can be made 24 hours a day, 7 days a week. For more information on electronic prior authorization (ePA) and to register, go to **Caremark.com/ePA.**
Phone (4-5 **minutes** for response)	The FEP Clinical Call Center can be reached at **(877)-727-3784** between the hours of 7AM-9PM Eastern Time. A live representative will assist with the Prior Authorization, asking for the same information contained on the attached form. Please review the form and have your answers ready for faster service. The process over the phone takes on average between 4 and 5 minutes.
Fax (3-5 **days** for response)	Fax the attached form to **(877)-378-4727**. Requests sent via fax will be processed and responded to within 5 business days. The form must be filled out completely, if there is any missing information the Prior Authorization request cannot be processed. ***Please only fax the completed form once as duplicate submissions may delay processing times.***