

BlueShield. REVLIMID Federal Employee Program. PRIOR APPROVAL REQUEST

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

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.						
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	5:		
City:	State:	Zip:	City:	Sta	ate:	Zip:
Patient ID: R			Physician Signature:	I		
	P	HYSICIAN C	OMPLETES			

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**, <u>excluding samples</u>? \Box Yes \Box No* **If NO*, are the prescriber and the patient certified with the Lenalidomide REMS program? \Box Yes \Box No
 - □ Multiple Myeloma (MM)
 - a. Has the patient been on Revlimid continuously for the last **6 months**, <u>excluding samples</u>? \Box Yes \forall *If NO*, please answer the following questions:
 - i. Will Revlimid be used in combination with dexamethasone or another corticosteroid? \Box Yes \Box 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 , <u>excluding samples</u> ? U Yes	□No*
*If NO, please answer the following questions:	

- i. Does the patient have low or intermediate -1 risk myelodysplastic syndromes? UYes No
- ii. Does the patient have transfusion-dependent anemia? \Box Yes \Box No
- iii. Are the prescriber and the patient certified with the Lenalidomide REMS program? The Second Sec

Non-Hodgkin Lymphoma (NHL)

a. What is the specific histology, or specific type, of the	e non-Hodgkin lymphoma? <i>Please select answer below:</i>
□AIDS-related diffuse large B-cell lymphoma	☐Mantle cell lymphoma (MCL)
Castleman's disease	□Marginal zone lymphoma
Chronic lymphocytic leukemia (CLL)	Primary cutaneous B-cell lymphoma
Diffuse large B-cell lymphoma	□Primary effusion lymphoma
□Follicular cell lymphoma	□Small lymphocytic lymphoma (SLL)
□Nongastric/Gastric mucosa associated lymphoid tissue	(MALT) lymphoma
Other (<i>please specify</i>):	

b. Is the patient's disease relapsed, refractory, or progressive? \Box Yes \Box No

c. Has the patient been on Revlimid continuously for the last **6 months**, <u>excluding samples</u>? \Box Yes \Box No* **If NO*, are the prescriber and the patient certified with the Lenalidomide REMS program? \Box Yes \Box No

Systemic light chain amyloidosis

a. Has the patient been on Revlimid continuously for the last **6 months**, <u>excluding samples</u>? \Box Yes \Box No* **If NO*, are the prescriber and the patient certified with the Lenalidomide REMS program? \Box Yes \Box No

□ Other diagnosis (*please specify*): _

The information provided on this form will be used to determine the provision of healthcare benefits under a U.S. federal government program, and any falsification of records may subject the provider to prosecution, either civilly or criminally, under the False Claim Acts, the False Statements Act, the mail or wire fraud statutes, or other federal or state laws prohibiting such falsification. **Prescriber Certification:** I certify all information provided on this form to be true and correct to the best of my knowledge and belief. I understand that the insurer may request a medical record if the information provided herein is not sufficient to make a benefit determination or requires clarification and I agree to provide any such information to the insurer. Revlimid – FEP MD Fax Form Revised 5/27/2022



REVLIMID

Federal Employee Program. PRIOR APPROVAL REQUEST

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. <u>Please only fax the completed form once as</u> <u>duplicate submissions may delay processing</u> <u>times.</u>

faster	Introducing ePA! Online Prior
easier	Authorizations in minutes through Caremark.com/ePA. Sign up today!
better	
	CVS/caremark [.] 🥰

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