CVS CAREMARK

Fax Referral To: 800-323-2445

Phone: 866-278-6634

Revlimid® (lenalidomide)
Enrollment Form
For Blue Cross Blue Shield of Rhode Island Members

Date: _____ **Needs by Date (Please Specify):** _____

Ship to: ☐ **Patient** ☐ **Office** ☐ **Other:** _____

PATIENT INFORMATION

*(Complete the following or **send patient demographic sheet**)*

Patient Name: _____
Address: _____
City, State, Zip: _____
Home Phone: _____
Alternate Phone: _____
SS #: _____
Insurance ID: _____
Date of Birth: _____ Gender: _____

PRESCRIBER INFORMATION

Prescriber's Name: _____
State License #: _____ UPIN: _____
DEA #: _____ NPI #: _____
Group or Hospital: _____
Address: _____
City, State Zip: _____
Phone: _____ Fax: _____
Contact Person: _____
Contact Phone: _____

INSURANCE INFORMATION *(If available, please copy and attach the front and back of insurance and prescription drug card)*

Primary Insurance: Subscriber: _____ Subscriber ID#: _____ Name of Insurer: **Blue Cross Blue Shield of RI**

Secondary Insurance: Subscriber: _____ Subscriber ID#: _____ Name of Insurer: _____

STATEMENT OF MEDICAL NECESSITY for BCBS of Rhode Island Members

Diagnosis (ICD-9 Code): ☐ 203.0 Multiple Myeloma ☐ 238.7 Lymphoproliferative disorders • Date of Diagnosis: _____

☐ Other: _____

APPROVAL CRITERIA: CHECK ALL BOXES THAT APPLY.

NOTE: Any areas not filled out are considered not applicable to your patient & MAY AFFECT THE OUTCOME of this request.

- Patient has a diagnosis of transfusion-dependent anemia associated with low-or intermediate-1-risk myelodysplastic syndromes (MDS) associated with a deletion of 5q cytogenetic abnormality; ☐ Yes ☐ No
- Patient has a diagnosis of multiple myeloma and meets the following: ☐ Yes ☐ No
- Patient has been using in combination with dexamethasone; ☐ Yes ☐ No
- Patient has received at least one prior therapy including but not limited to: ☐ Yes ☐ No
- Vincristine + Doxorubicin + dexamethasone (VAD); ☐ Yes ☐ No
- Melphalan/Cyclophosphomide + prednisone; ☐ Yes ☐ No
- Thalidomide + dexamethasone; ☐ Yes ☐ No
- Allogeneic or autologous stem-cell or bone marrow transplantation; ☐ Yes ☐ No
- Vincristine + Carmustine + Melphalan + Cyclophosphomide + prednisone (VBMCP); ☐ Yes ☐ No
- Etopaside + Dexamethasone + Cytarabine + Cisplatin (EDAP); ☐ Yes ☐ No
- High-dose dexamethasone; Interferon-alfa; Arsenic Trioxide; Liposomal Doxorubicin; Vincristine + Dexamethasone ☐ Yes ☐ No
- Other (please specify): _____ ☐ Yes ☐ No

Note: The following compendia, American Hospital Formulary Service, U.S. Pharmacopeia Dispensing Information, National Comprehensive Cancer Network NCCN), and Drug & Biologics Compendium™ Category of Evidence and Consensus are considered during prior authorization review if the drug is being prescribed for a condition not listed above. Additional information may be requested if documentation in the compendia is lacking.

Medical Necessity (please attach all supporting documentation):

_____

_____

PRESCRIPTION INFORMATION

• **Authorization #:** _____

Requests for increased quantities may be approved for 1 month only when the request is for a 5mg* dose that is being titrated to 10mg.

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
☐ Revlimid® (lenalidomide)	☐ 5mg ☐ 10mg ☐ 15mg ☐ 25mg	☐ Take one capsule by mouth once a day continuously *(MDS – ICD-9: 238.7)* ☐ Take one capsule by mouth for 21 days and then rest for 7 days *(MM – ICD-9: 203.0)* ☐ Other: _____		

PRODUCT SUBSTITUTION PERMITTED (Date) DISPENSE AS WRITTEN (Date)