Prior Authorization Request Form for
lenalidomide **(Revlimid)**

JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE
7231 Parkway Drive, Suite 100, Hanover, MD 21076

USFHP Pharmacy Prior Authorization Form

FAX Completed Form and Applicable Progress Notes to: (410) 424-4037

To be completed by Requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

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

[08 April 2020]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: