REVLIMID

Prior Authorization Form

IF THIS IS AN URGENT REQUEST, Please Call UPMC Health Plan Pharmacy Services.
Otherwise please return completed form to:

UPMC HEALTH PLAN PHARMACY SERVICES PHONE 800-979-UPMC (8762) FAX 412-454-7722

PLEASE TYPE OR PRINT NEATLY. *Incomplete responses may delay this request.*

Office Contact:	**Provider Specialty:**
Provider First Name:	**Provider Last Name:**
Provider Phone:	**Provider Fax:**

Patient Name:	**Patient UPMC Health Plan ID Number:**	**Patient Age:**	**Patient DOB:**
Drug Requested: ❑ **Brand** ❑ **Generic**	**Strength:**	**Frequency:**	**Expected length of therapy:**

Generic equivalent drugs will be substituted for Brand name drugs unless you specifically indicate otherwise.

❑ **New medication** ❑ **Ongoing medication**	**If ongoing, provide date started:**	**If medication is ongoing, Did member Show improvement while on therapy?**	❑**Yes** ❑**No**

Place of administration? ❑**Physician Office** ❑**Hospital/Facility**

Please provide facility/provider name and address:

Please indicate how medication will be billed:
- ❑ **Billed directly by the provider via JCODE** **Provide JCODE:____________________**
- ❑ **Billed by a pharmacy and delivered to the provider**
- ❑ **Billed by a pharmacy and delivered to the patient**

Please provide pertinent progress notes and lab/radiology reports that describe the member's current disease status. ☐ **Chart documentation enclosed** ☐ **Chart documentation not available**

Please indicate the diagnosis and answer the corresponding questions:

❑ Myelodysplastic Syndrome	Does the member have transfusion-dependent anemia? ❑Yes ❑No
	Please indicate MDS risk category:
	❑ Low ❑ Intermediate-1
	❑ Intermediate-2 ❑ High
	Is MDS associated with a deletion 5q cytogenetic abnormality? ❑Yes ❑No
❑ Multiple Myeloma	Is Revlimid being used in combination with dexamethasone? ❑Yes ❑No
	If No, Why?
	Has the member tried received at least 1 prior therapy? ❑Yes ❑No If yes, please list below:

Medication Name	Strength/Frequency	Dates of Therapy	Reason for Discontinuation

❑ **Other Diagnosis, please list:**

Please provide clinical literature/studies to support request for off-label use.
☐ **Clinical literature/studies enclosed** ☐ **Clinical literature/studies not available**

Is Revlimid being used in combination with any other therapies? ❑**Yes** ❑**No** **If yes, please list below.**

Medication Name	Strength/Frequency	Dates of Therapy

Please list below any other previous therapies tried:

Medication Name	Strength/Frequency	Dates of Therapy	Reason for Discontinuation

Please provide any additional information which should be considered in the space below: