



Send completed form to:
 Peach State Health Plan Pharmacy Department
Fax: 1-866-374-1579

Revlimid

Prior Authorization Request

This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form toll-free to Peach State Health Plan at 1-866-374-1579.** If you have questions regarding the prior authorization, eligibility, drug copay or medication delivery; please contact Peach State Health Plan at **1-800-514-0083 option # 2.**

Patient Name: _____ **Date:** _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____
Physician Office Address: _____

1. What drug is being prescribed? Revlimid Other _____
2. What is the diagnosis?
 Myelodysplastic syndrome (MDS) Multiple myeloma (MM) Other _____
3. **What is the ICD9?** _____
4. Will the patient be monitored for signs and symptoms of thromboembolism? Yes No
5. What is the patient's gender? Female Male **If Male, Skip to #8*
6. Is the patient of childbearing potential? Yes No **If No, Skip to #9*
7. Has the pregnancy been excluded (**confirmed by 2 negative urine or serum pregnancy tests**)?
 Yes No
8. Has the patient been instructed on the importance and proper utilization of appropriate contraceptive methods? Yes No
9. Is the patient currently receiving Revlimid therapy? Yes No **If No, Skip to Diagnosis Section*
10. Is the patient continuing to benefit from Revlimid therapy? Yes No

Complete the Section below designated for the patient's diagnosis

SECTION A: Diagnosis Myelodysplastic syndrome (MDS)

11. Is MDS Low or Intermediate-1 risk? Yes No
12. Does the patient have 5q deletion cytogenetic abnormality? Yes No
****ATTACH lab results****
13. Does (did) the patient have transfusion-dependent anemia? Yes No

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Patient Name: _____ **Patients Date of Birth:** _____
Patients ID : _____

SECTION A: Diagnosis Multiple myeloma (MM)

14. Has the patient received at least one prior therapy for MM? Yes No
15. Is Revlimid being used in combination with dexamethasone? Yes No

Information given on this form is accurate as of this date:

X _____
Prescriber or Authorized Signature **Date (mm/dd/yy)**

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