Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.
Lenalidomide (Revlimid) Prior Authorization (PA)
Pharmacy Benefits Prior Authorization Help Desk
Length of Authorizations: Initial- 12 months; Continuation- 12 months

Instructions:

This form is used by Kaiser Permanente and/or participating providers for coverage of **Lenalidomide (Revlimid) .** Please complete and fax this form back to Kaiser Permanente within 24 hours [fax: 1-866-331-2104]. If you have any questions or concerns, please call 1-866-331-2103. **Requests will not be considered unless this form is complete. The KP-MAS Formulary can be found at: http://pithelp.appl.kp.org/MAS/formulary.html**

1 – Patient Information

Patient Name: _____ Kaiser Medical ID#: _____ Date of Birth: _____

2 – Provider Information

Prescriber specialty: □ Hematologist □ Oncologist □ Other: _____

If consulted with a specialist, specialist name and specialty: _____

Provider Name: _____ Provider NPI: _____

Provider Address: _____

Provider Phone #: _____Provider Fax #: _____

Please check the boxes that apply:
□Initial Request □ Continuation of Therapy Request

3 – Pharmacy Information

Pharmacy Name: _____ Pharmacy NPI: _____

Pharmacy Phone #_____ Pharmacy Fax #: _____

4 – Drug Therapy Requested

Drug 1: Name/Strength/Formulation: _____
Sig: _____

Drug 2: Name/Strength/Formulation: _____
Sig: _____

5 – Diagnosis

Please select Indication:
□ Multiple Myeloma
□ Myelodysplastic Syndromes (MDS)
□ B-Cell Lymphomas
□ Myelofibrosis-Associated Anemia
□ Hodgkin Lymphoma
□ Systemic Light Chain Amyloidosis
□ Chronic Lymphocytic Leukemia (CLL)
□ Small Lymphocytic Leukemia (SLL)
□ Primary Cutaneous Lymphomas
□ T-Cell Lymphomas
□ Other: _____

6–Clinical Criteria

Initial Therapy:

Multiple Myeloma

1. Does the member have diagnosis of multiple myeloma? □ No □ Yes

Myelodysplastic Syndromes (MDS)

1. Does the member have a diagnosis of anemia due to MDS with 5q deletion? □ No □ Yes
2. Does the member have a diagnosis of anemia due to MDS without 5q deletion and one of the following: □ No □ Yes
   a) □ No □ Yes Serum erythropoietin level >500 mU/mL
   b) □ No □ Yes History of failure or contraindication to erythropoietins

B-Cell Lymphomas

1. Does the member have a diagnosis of one of the following (please indicate)?

□ Mantle Cell Lymphoma (MCL)	□ Follicular Lymphoma	□ Nodal Marginal Zone Lymphoma	□ Splenic Marginal Zone Lymphoma
□ Diffuse Large B-Cell Lymphoma	□ Gastric MALT Lymphoma	□ Non-Gastric MALT Lymphoma	□ Other: _____

2. Does the member have **both** of the following (please indicate)? □ No □ Yes
   a) Diagnosis of one of the following:

□ AIDS-Related B-Cell Lymphoma	□ Diffuse Large B-Cell Lymphoma	□ Post-Transplant Lymphoproliferative Disorders
□ Castleman's Disease (CD)	□ High-Grade B-Cell Lymphoma	□ Primary CNS Lymphoma
□ Other: _____		

b) □ No □ Yes Lenalidomide (Revlimid) is not being used as first-line therapy

Myelofibrosis-Associated Anemia

1. Does the member have **both** of the following?
   a) □ No □ Yes Diagnosis of myelofibrosis-associated anemia AND
   b) One of the following:

□ No □ Yes Serum erythropoietin level >500 mU/mL	□ No □ Yes History of failure or contraindication to erythropoietins

Hodgkin Lymphoma

1. Does the member have ALL the following?

□ No □ Yes Diagnosis of Hodgkin Lymphoma	□ No □ Yes Relapsed or refractory disease	□ No □ Yes Used as third-line or subsequent therapy

Systemic Light Chain Amyloidosis

1. Does the member have a diagnosis of systemic light chain amyloidosis? □ No □ Yes

Chronic Lymphocytic Leukemia (CLL)/Small Lymphocytic Leukemia (SLL)

1. Does the member have both of the following?
   a) □ No □ Yes Diagnosis of chronic lymphocytic leukemia/small lymphocytic lymphoma AND
   b) One of the following:

□ No □ Yes Used for relapsed or refractory disease	□ No □ Yes Used after first line chemoimmunotherapy maintenance	□ No □ Yes Used after second-line maintenance therapy

Primary Cutaneous Lymphomas

1. Does the member have a diagnosis of one of the following?

□ No □ Yes Mycosis Fungoides	□ No □ Yes Sezary Syndrome	□ No □ Yes Primary Cutaneous CD30+ T-Cell Lymphoproliferative Disorder

T-Cell Lymphomas

1. Does the member have **both** of the following?
   a) □ No □ Yes Diagnosis of T-Cell Lymphoma
   b) □ No □ Yes Lenalidomide (Revlimid) is not being used as first line therapy

Continuation of Therapy:

1. The member does NOT show evidence of progressive disease while on therapy? □ No □ Yes

7 – Provider Sign-Off

Additional Information – Please provide any additional information that should be taken into consideration.

_____

I certify that the information provided is accurate. Supporting documentation is available for State audits.

Provider Signature:	**Date:**

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