

**Revlimid**  
**Prior Authorization Request**

**Send completed form to: Case Review Unit, CVS Caremark Prior Authorization Fax: 1-866-249-6155**

CVS Caremark administers the prescription benefit plan for the patient identified. 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 to CVS Caremark toll-free at 1-866-249-6155.** If you have questions regarding the prior authorization, please contact CVS Caremark at **1-866-814-5506**. For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

**Patient's Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
**Patient's ID:** \_\_\_\_\_ **Patient's Date of Birth:** \_\_\_\_\_  
**Physician's Name:** \_\_\_\_\_ **NPI#:** \_\_\_\_\_  
**Specialty:** \_\_\_\_\_ **Physician Office Fax:** \_\_\_\_\_  
**Physician Office Telephone:** \_\_\_\_\_  
**Request Initiated For:** \_\_\_\_\_

- What is the patient's diagnosis?
 

<input type="checkbox"/> Multiple myeloma	<input type="checkbox"/> Systemic light chain amyloidosis
<input type="checkbox"/> Non-Hodgkin lymphoma	<input type="checkbox"/> Classical Hodgkin lymphoma
<input type="checkbox"/> Myelodysplastic syndrome	<input type="checkbox"/> Other _____
<input type="checkbox"/> Myelofibrosis-associated anemia	

2. What is the ICD-10 code? \_\_\_\_\_

*Complete the following section based on the patient's diagnosis, if applicable.*

Section A: Non-Hodgkin Lymphoma

- Which of the following NHL subtypes does the patient have?
 

<input type="checkbox"/> Diffuse large B-cell lymphoma	<input type="checkbox"/> Nongastric/gastric MALT lymphoma
<input type="checkbox"/> Mantle cell lymphoma	<input type="checkbox"/> Splenic marginal zone lymphoma
<input type="checkbox"/> Chronic lymphocytic leukemia (CLL) /	<input type="checkbox"/> Castleman's disease
small lymphocytic lymphoma (SLL)	<input type="checkbox"/> Primary cutaneous anaplastic large cell lymphoma (ALCL)
<input type="checkbox"/> Primary cutaneous B-cell lymphoma	<input type="checkbox"/> Adult T-cell leukemia/lymphoma
<input type="checkbox"/> AIDS-related diffuse large B-cell lymphoma	<input type="checkbox"/> Mycosis fungoides (MF)/Sezary syndrome (SS)
<input type="checkbox"/> Primary effusion lymphoma	<input type="checkbox"/> Angioimmunoblastic T-cell lymphoma (AITL)
<input type="checkbox"/> Lymphoma associated with Castleman's disease	<input type="checkbox"/> Enteropathy-associated T-cell lymphoma
<input type="checkbox"/> Follicular lymphoma	
<input type="checkbox"/> Peripheral T-cell lymphoma not otherwise specified (PTCL NOS)	
<input type="checkbox"/> Other _____	

4. *If Castleman's disease*, what is the form of the disease?  Unicentric  Multicentric

Section B: Myelodysplastic Syndrome

- What is the International Prognostic Scoring System (IPSS) risk category of the disease?
 

<input type="checkbox"/> Low	<input type="checkbox"/> Intermediate-1	<input type="checkbox"/> Intermediate-2	<input type="checkbox"/> High
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- Does the patient have symptomatic anemia?  Yes  No

***I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.***

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

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