



Date of Request: \_\_\_\_\_

**Sterling Retiree Rx Prior Authorization Form****REVLIMID (Lenalidomide)****Coverage Criteria**

Multiple Myeloma (MM), Transfusion-dependent anemia due to Low- or Intermediate-1-risk myelodysplastic syndromes (MDS) associated with a deletion 5q cytogenetic abnormality.  
Monitor CBC on regular basis.

**Required Medical Information**

If female of child bearing potential, pregnancy ruled out by 2 negative urine or serum pregnancy tests.  
For MM, requirement of combination therapy with dexamethasone and at least one prior MM treatment.  
For MDS, diagnosis of anemia due to Low- or Intermediate-1-risk MDS associated with a deletion 5q cytogenetic abnormality; transfusion dependent.

**Exclusion Criteria**

Pregnancy

**Member Information**

<b>Name</b>					
<b>Enrollment/Card-holder ID Number</b>					
<b>Group/Plan</b>		<b>Male</b>		<b>Female</b>	
<b>Date of Birth</b>		<b>Age</b>		<b>Weight in Kg</b>	
<b>Street Address</b>					
<b>City</b>		<b>State</b>		<b>Zip</b>	

**Physician Information**

<b>Name</b>					
<b>Agent</b>		<b>Contact Name</b>			
<b>Specialty/Office</b>					
<b>Clinic Name</b>					
<b>Street Address</b>					
<b>City</b>		<b>State</b>		<b>Zip</b>	
<b>Phone</b>		<b>Fax</b>			

**Requested Drug**

<b>REVLIMID</b>	<b>Reason for Request</b>	
<b>Condition/Diagnosis Related</b>		

**Clinical Drug/Lab History Pertinent to Request**

<b>Labs: Baseline/Ongoing</b>	<b>Strength/Dosage</b>		
<b>Formulary Alternative(s) Attempted?</b>	<b>Yes:</b>		<b>No:</b>
<b>Please List Alternative Formulary Drugs</b>			
<b>Comments</b>			

Physician Signature: \_\_\_\_\_

Fax Form to 1-877-847-9904