



Date \_\_\_\_\_

Client \_\_\_\_\_

# PRIOR AUTHORIZATION QUESTIONNAIRE - Revlimid® (lenalidomide)

M.D. Last Name: \_\_\_\_\_ M.D. First Name: \_\_\_\_\_

Physician Phone: \_\_\_\_\_ Physician Fax: \_\_\_\_\_

Patient \_\_\_\_\_ ID# \_\_\_\_\_ DOB \_\_\_\_\_

**TO ENSURE PROMPT PROCESSING PLEASE COMPLETE ALL OF THE QUESTIONS.**

**PLEASE NOTE: FOR ALL REQUESTS, PLEASE ATTACH THE MOST RECENT COPY OF THE PATIENT'S PROGRESS NOTES**

- |   |     |    |
|---|-----|----|
| 1. Does the patient have myelodysplastic syndrome? (If not, skip to #6)   | Yes | No |
| 2. Does the patient have a diagnosis of anemia (e.g., hemoglobin $\leq$ 10 mg/dL)?  | Yes | No |
| 3. Is the patient "transfusion-dependent" (e.g., the patient has required $\geq$ 2 units of red blood cells within the prior 8 weeks)?                                | Yes | No |
| 4. Is the anemia of the patient due to Low- or Intermediate-1-risk (International Prognostic Scoring System [IPSS] score of 0, 0.5, or 1.0) myelodysplastic syndrome? | Yes | No |
| 5. Does the patient have an associated "deletion 5q cytogenetic abnormality"?   | Yes | No |
| 6. Does the patient have multiple myeloma?  | Yes | No |
| 7. List previously tried chemotherapy drugs: _____  |     |    |
| 8. Is the prescriber registered in the RevAssist <sup>SM</sup> program?   | Yes | No |
| 9. Will Revlimid be used in combination with 40 mg/day of dexamethasone on days per the package insert?   | Yes | No |
| 10. Has the patient or his/her legal guardian signed the informed consent form?   | Yes | No |
| 11. Will the complete blood count (CBC) of the patient be monitored weekly for the first eight weeks of therapy and at least monthly thereafter?                      | Yes | No |
| 12. Is the patient $\geq$ 65 years of age? (if YES, skip to question 14.)   | Yes | No |
| 13. Does the patient have impaired renal function (e.g., creatinine clearance $\leq$ 80mL/min)? (If NO, Skip to #15)  | Yes | No |
| 14. Will the renal function of the patient be monitored on a regular basis?   | Yes | No |
| 15. Is the patient a female? (If NO, then skip to #19)  | Yes | No |
| 16. Is the patient of childbearing potential? (If NO, then skip to #19)   | Yes | No |
| 17. Has pregnancy been excluded as confirmed by a negative urine or serum pregnancy test?   | Yes | No |
| 18. Has the patient been instructed on appropriate contraceptive methods for Revlimid use?  | Yes | No |

19. Strength Requested: \_\_\_\_\_ SIG: \_\_\_\_\_

Physician Signature or name of person providing answers \_\_\_\_\_

Physician Comments \_\_\_\_\_

Send or Fax completed form to:  
**877-329-7279**

RESTAT  
11900 W. Lake Park Dr.  
Milwaukee, WI 53224

QUESTIONS PLEASE CALL:  
**877-526-9906**

www.restat.com