



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 SM 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
P.O. BOX 758
WEST BEND, WI 53095

QUESTIONS PLEASE CALL:
877-526-9906

www.restat.com