Prescriber Criteria Form Revlimid 2025 PA Fax 386-A v1 010125.docx Revlimid (lenalidomide) Coverage Determination
This fax machine is located in a secure location as required by HIPAA regulations. Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673.** Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Revlimid (lenalidomide).

Drug Name: Revlimid (lenalidomide)

Patient Name:		
Patient ID:		
Patient DOB:	**Patient Phone:**	
Prescriber Name:		
Prescriber Address:		
City:	**State:**	**Zip:**
Prescriber Phone:	**Prescriber Fax:**	
Diagnosis:	**ICD Code(s):**	

Please circle the appropriate answer for each question.			
1	Does the patient have a diagnosis of multiple myeloma? [If yes, then no further questions.]	Yes ◯	No ◯
2	Does the patient have a diagnosis of T-cell lymphoma? [If no, then skip to question 4.]	Yes ◯	No ◯
3	Is the T-cell lymphoma subtype ANY of the following: A) peripheral T-Cell lymphomas not otherwise specified, B) angioimmunoblastic T-cell lymphoma (AITL), C) enteropathy-associated T-cell lymphoma, D) monomorphic epitheliotropic intestinal T-cell lymphoma, E) nodal peripheral T-cell lymphoma, F) follicular T-cell lymphoma, G) adult T-cell leukemia/lymphoma, H) hepatosplenic T-cell lymphoma? [No further questions.]	Yes ◯	No ◯
4	Does the patient have a diagnosis of myelodysplastic syndrome (MDS)? [If no, then skip to question 7.]	Yes ◯	No ◯
5	Does the patient have lower risk myelodysplastic syndrome per the Revised International Prognostic Scoring System (IPSS-R), International Prognostic Scoring System (IPSS), or World Health Organization (WHO) classification-based Prognostic Scoring System (WPSS)? [If no, then no further questions.]	Yes ◯	No ◯

6	Does the patient have symptomatic anemia? [No further questions.]	Yes ◯	No ◯
7	Does the patient have a diagnosis of myelofibrosis-associated anemia? [If yes, then no further questions.]	Yes ◯	No ◯
8	Does the patient have a diagnosis of systemic light chain amyloidosis? [If yes, then no further questions.]	Yes ◯	No ◯
9	Does the patient have a diagnosis of classical Hodgkin lymphoma? [If yes, then no further questions.]	Yes ◯	No ◯
10	Does the patient have a diagnosis of POEMS (polyneuropathy, organomegaly, endocrinopathy, monoclonal endocrinopathy, monoclonal protein, skin changes) syndrome? [If yes, then no further questions.]	Yes ◯	No ◯
11	Does the patient have a diagnosis of myeloproliferative neoplasm? [If yes, then no further questions.]	Yes ◯	No ◯
12	Does the patient have a diagnosis of Kaposi sarcoma? [If yes, then no further questions.]	Yes ◯	No ◯
13	Does the patient have a diagnosis of primary central nervous system (CNS) lymphoma? [If yes, then no further questions.]	Yes ◯	No ◯
14	Does the patient have a diagnosis of chronic lymphocytic leukemia (CLL)/small lymphocytic lymphoma (SLL)? [If yes, then no further questions.]	Yes ◯	No ◯
15	Does the patient have a diagnosis of B-cell lymphoma? [If no, then skip to question 17.]	Yes ◯	No ◯
16	Is the B-cell lymphoma subtype ANY of the following: A) human immunodeficiency virus (HIV)-related B-cell lymphomas, B) mantle cell lymphoma, C) monomorphic post-transplant lymphoproliferative disorder, D) diffuse large B-cell lymphoma, E) multicentric Castleman's disease, F) high-grade B-cell lymphomas, G) histologic transformation of indolent lymphomas to diffuse large B-cell lymphoma, H) follicular lymphoma, I) marginal zone lymphoma? [No further questions.]	Yes ◯	No ◯
17	Does the patient have a diagnosis of ANY of the following histiocytic neoplasms: A) Rosai-Dorfman disease, B) Langerhans Cell Histiocytosis?	Yes ◯	No ◯

Comments:	_____

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.

Prescriber (or Authorized) Signature: _____ Date:_____