Pharmacy Prior Authorization

AETNA BETTER HEALTH NEW JERSEY (MEDICAID)

Revlimid (Medicaid)

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Aetna Better Health New Jersey at **1-855-296-0323**.
When conditions are met, we will authorize the coverage of Revlimid (Medicaid).
Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

Drug Name *(circle drug)*

Revlimid (lenalidomide)

Other, specify drug _____

Quantity _____ Frequency _____ Strength _____

Route of administration _____ Expected length of therapy _____

Member information

Member name: _____

Member ID: _____

Member Group No.: _____

Member DOB: _____

Member phone: _____

Prescribing physician

Physician name: _____

Specialty: _____ NPI number: _____

Physician fax: _____ Physician phone: _____

Physician address: _____ City, state, zip: _____

Diagnosis: _____ **ICD Code:** _____

Circle the appropriate answer for each question.

1. Has this plan authorized this medication in the past for this member (i.e., previous authorization is on file under this plan)? Y N

   [If no, skip to question 4.]

2. Does the member show evidence of progressive disease while on therapy? Y N

   [If yes, no further questions.]

3. Does the member have unacceptable toxicity from therapy? Y N

   [No further questions]

4. Does the member have a diagnosis of multiple myeloma? Y N

   [If no, skip to question 7.]

5. Is Revlimid requested for use as primary therapy in combination with dexamethasone? Y N

   [If yes, skip to question 27.]

6. Is Revlimid requested for use as maintenance therapy in a member following stem cell transplantation? Y N

   [If yes, skip to question 27.]

   [If no, then no further questions.]

7. Does the member have a diagnosis of mantle cell lymphoma (MCL)? Y N

   [If no, skip to question 11.]

8. Is Revlimid requested for the treatment of the disease after relapse or progression with two prior therapies, one of which includes Velcade (bortezomib)? Y N

   If yes, please list prior therapies tried or submit records: _____

   [If yes, skip to question 27.]

9. Is Revlimid requested for treatment of the disease as second-line therapy for relapsed, refractory, or progressive disease? Y N

   [If yes, skip to question 27.]

10. Is Revlimid requested for treatment of the disease as induction therapy in combination with rituximab? Y N

    [If yes, skip to question 27.]

    [If no, then no further questions.]

11. Does the member have a diagnosis of myelodysplastic syndrome (MDS)? Y N

    [If no, skip to question 14.]

12. Is Revlimid requested for the treatment of symptomatic anemia associated with the 5q-deletion cytogenetic abnormality? Y N

    [If yes, then skip to question 27.]

13. Is Revlimid requested for the treatment of a member who does not have 5q- Y N

deletion with serum erythropoietin levels greater than 500 mU/ml or has a history of failure, contraindication, or intolerance to a preferred erythropoietin?

[If yes, skip to question 27.]

[If no, then no further questions.]

14. Is Revlimid requested for the treatment of diffuse large B-cell lymphoma as second-line or therapy for relapsed/refractory disease? Y N

[If yes, skip to question 27.]

15. Is Revlimid requested for the treatment of follicular lymphoma? Y N

[If yes, skip to question 27.]

16. Is Revlimid requested for the treatment of gastric or nongastric mucosa-associated lymphoid tissue (MALT) lymphoma? Y N

[If yes, skip to question 27.]

17. Is Revlimid requested for the treatment of chronic lymphocytic leukemia/small lymphocytic lymphoma for relapsed or refractory disease? Y N

[If yes, skip to question 27.]

18. Is Revlimid requested for the treatment of systemic light chain amyloidosis, in combination with dexamethasone? Y N

[If yes, skip to question 27.]

19. Is Revlimid requested for the treatment of Hodgkins lymphoma for relapsed/refractory disease? Y N

[If yes, skip to question 27.]

20. Is Revlimid requested for the treatment of adult T-cell leukemia/lymphoma for nonresponders to first-line therapy or following high dose therapy/autologous stem cell rescue? Y N

[If yes, skip to question 27.]

21. Is Revlimid requested for the treatment of peripheral T-cell lymphoma as second-line or subsequent therapy for relapsed or refractory disease? Y N

[If yes, skip to question 27.]

22. Is Revlimid requested for the treatment of splenic or nodal marginal zone lymphoma? Y N

[If yes, skip to question 27.]

23. Is Revlimid requested for the treatment of myelofibrosis associated anemia with serum erythropoietin levels greater than or equal to 500 mU/ml or failure with a preferred erythropoiesis stimulating agent? Y N

    [If yes, skip to question 27.]

24. Is Revlimid requested for the treatment of acquired immune deficiency syndrome (AIDS)-related B-cell lymphoma as second-line or subsequent therapy? Y N

    [If yes, skip to question 27.]

25. Is Revlimid requested for the treatment of Castleman's disease as second-line or subsequent therapy for disease that has progressed following therapy for relapsed/refractory or progressive disease? Y N

    [If yes, skip to question 27.]

26. Is Revlimid requested for the treatment of mycosis fungoides/Sezary syndrome? Y N

    [If no, then no further questions.]

27. Is Revlimid prescribed by, or in consultation with, an oncologist? Y N

    [If no, then no further questions.]

28. Is the member 18 years of age or older? Y N

Comments:

I affirm that the information given on this form is true and accurate as of this date.

Prescriber (Or Authorized) Signature **Date**