

PHYSICIAN PRIOR AUTHORIZATION REQUEST FORM BlueChoice[®] HealthPlan

Patient Information	
Name:	Insurance ID #:
Address:	Birthdate:

Provider Information	
Physician's Name:	Physician DEA #:
Phone:	Fax:
Office Address:	
Diagnosis:	ICD-9 Code:

When this form is completed, please fax back to Caremark at 888-836-0730.

This fax machine is located in a HIPAA-compliant, secure location.

Call Caremark at 800-294-5979 with any questions concerning prior authorization procedures.

On behalf of BlueChoice HealthPlan, Caremark assists in the administration of this program.

Caremark is an independent company that administers prescription drug benefits.

1. Is the patient currently receiving Revlimid treatment? [If yes, then no further questions.] Y N
2. Does the patient have a diagnosis of active myeloma, progressive solitary plasmacytoma or smoldering myeloma that has progressed beyond stage II? [If no, then skip to question 8.] Y N
3. Is Revlimid requested as primary induction therapy? [If yes, then skip to question 10.] Y N
4. Is Revlimid requested for treatment of relapsed or refractory disease? [If yes, then skip to question 23.] Y N
5. Is Revlimid requested as monotherapy for maintenance in myeloma? [If no, then no further questions.] Y N
6. Has the patient responded to primary induction therapy? [If yes, then skip to question 23.] Y N
7. Has the patient received stem cell transplant? [If yes, then skip to question 23.] [If no, then no further questions.] Y N
8. Does the patient have a diagnosis of systemic light chain amyloidosis? [If no, then skip to question 11.] Y N

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| 9. Is therapy requested as primary treatment? [If no, then no further questions.] | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 10. Will Revlimid be used in combination with dexamethasone? [If yes, then skip to question 23.] [If no, then no further questions.] | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 11. Is Revlimid requested as monotherapy for the treatment of relapsed, refractory or progressive mantle cell lymphoma? [If yes, then skip to question 23.] | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 12. Does the patient have a diagnosis of relapsed/refractory diffuse large B-cell lymphoma? [If yes, then skip to question 23.] | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 13. Does the patient have a diagnosis of Low or Intermediate-1 risk MDS? [If no, then skip to question 22.] | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 14. Has genetic testing been performed? [If no, then no further questions.] | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 15. Does the patient have a del(5q) cytogenetic abnormality? [If yes, then skip to question 20.] | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 16. Does the patient have symptomatic anemia due to MDS (e.g., pre-transfusion hemoglobin \leq 10 g/dL)? [If no, then no further questions.] | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 17. Has the patient tried and failed to respond to initial therapy with epoetin alfa or darbepoetin alfa? [If yes, then may skip to question 23.] | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 18. Does the patient have serum erythropoietin levels $>$ 500 mU/mL? [If no, then no further questions.] | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 19. Does the patient have a low probability of response to immunosuppressive therapy? [If yes, then skip to question 23.] [If no, then no further questions.] | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 20. Does the patient have transfusion-dependent anemia (i.e. required \geq 2 units of RBCs in previous 8 weeks)? [If yes, then skip to question 23.] | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 21. Does the patient have symptomatic anemia (hemoglobin $<$ 10 g/dL) with other clinically significant cytopenia(s) (platelet count $<$ 100,000/mcL or absolute neutrophil count $<$ 1,800/mcL)? [If yes, then skip to question 23.] [If no, then no further questions.] | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 22. Does the patient have a diagnosis of relapsed or refractory CLL? [If no, then no further questions.] | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 23. Will the patient be closely monitored for the signs and symptoms of thromboembolism on a regular basis while taking Revlimid? [If no, then no further questions.] | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 24. Is the patient a male? [If yes, then skip to question 27.] | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 25. Is the female patient of childbearing potential? [If no, then no further questions required.] | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 26. Has pregnancy been excluded as confirmed by two negative urine or serum pregnancy tests? [If no, then no further questions.] | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 27. Has the patient been instructed regarding the importance and the proper utilization of appropriate contraceptive methods for Revlimid use? | <input type="checkbox"/> Y | <input type="checkbox"/> N |

Comments: _____

Information on this form is accurate as of the date below.

Prescriber's Signature:	Date:
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