

Health New England
Medication Request Form (MRF)/Prescription Request
Revlimid® (lenalidomide)

DO NOT WRITE IN BLOCKED AREAS FOR INTERNAL USE ONLY
Contacted:
Physician:
Pharmacy:
Patient:

Prior Authorization

DO NOT WRITE IN BLOCKED AREAS FOR INTERNAL USE ONLY
Approved:
Quantity approved:
PA from and thru date:
PA #
Denied:
Returned:

Instructions:

This form is to be used by participating physicians and pharmacy providers to obtain coverage of **Revlimid® (lenalidomide)**. Please complete this form and fax to MedMetrics Health Partners at **(800) 550-9246**. If you have any questions regarding this process, please contact MedMetrics clinical call center at **(866) 209-1057**.

Medication Request Information (please complete each section of this form prior to transmittal):

Patient Information (all required)	Physician Information (all required)
Patient Name:	Physician Name:
Patient Cell Phone #: () -	Specialty:
Patient HNE ID#:	NPI #:
Patient Date of Birth:	HNE Provider #:
Allergies:	DEA #:
	Telephone #: () -
	Fax # (required): () -

Drug Information		
Requested Drug/Strength/Form: Revlimid® (lenalidomide)		
Dose, Directions, and length of treatment (please be specific):	Quantity (per month)- note: HNE allows maximum of 30 capsules per month	Refills:
Physician Signature:	Date:	

Please Check All That Apply:

- The prescribing physician is a hematologist or oncologist
- Diagnosis is Myelodysplastic Syndrome
- Diagnosis is Multiple Myeloma
- Patient has failed conventional, first line treatment
- Patient is 18 years of age or older
- Provider is registered in the RevAssist Program
- Patient is registered in the RevAssist Program
- Diagnosis is _____(please specify or attach references)