

APPLIES TO COMMERCIAL AND MEDICAID
Health New England
Medication Request Form (MRF)/Prescription Request
Revlimid® (lenalidomide)

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|--|
| 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)