

Prescriber Criteria Form  
 Revlimid 2026 PA Fax 386-A v1 010126.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:**

<b>Patient DOB:</b>	<b>Patient Phone:</b>
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**Prescriber Name:**

**Prescriber Address:**

<b>City:</b>	<b>State:</b>	<b>Zip:</b>
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<b>Prescriber Phone:</b>	<b>Prescriber Fax:</b>
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<b>Diagnosis:</b>	<b>ICD Code(s):</b>
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**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 epitheliotropc 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 systemic light chain amyloidosis? [If yes, then no further questions.]	Yes	No
8	Does the patient have a diagnosis of classical Hodgkin lymphoma? [If yes, then no further questions.]	Yes	No
9	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
10	Does the patient have a diagnosis of myeloproliferative neoplasm? [If yes, then no further questions.]	Yes	No
11	Does the patient have a diagnosis of Kaposi sarcoma? [If yes, then no further questions.]	Yes	No
12	Does the patient have a diagnosis of primary central nervous system (CNS) lymphoma? [If yes, then no further questions.]	Yes	No
13	Does the patient have a diagnosis of chronic lymphocytic leukemia (CLL)/small lymphocytic lymphoma (SLL)? [If yes, then no further questions.]	Yes	No
14	Does the patient have a diagnosis of multicentric Castleman's disease? [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) high-grade B-cell lymphomas, F) histologic transformation of indolent lymphomas to diffuse large B-cell lymphoma, G) follicular lymphoma, H) 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:	
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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:** \_\_\_\_\_