



**Physician's Prior Authorization Questionnaire  
Revlimid®**

**Patient:**

**ID#:**

**DOB:**

**Patient Address:**

Revlimid® is covered under certain clinical conditions. Please furnish the information below to assist us in making a determination of this patient's eligibility for coverage for treatment with this drug.

1. What is the patient's diagnosis? *(Please do not use codes.)* \_\_\_\_\_
2. Has the patient received prior therapy for this diagnosis?     Yes     No
3. What dose of Revlimid® is being requested (mg/day)? \_\_\_\_\_

**Revlimid® has a quantity limit of one (1) tablet per day.**

**The prescriber and patient must be registered with RevAssist<sup>SM</sup> in order to obtain the medication.  
RevAssist allows no more than a 28 day supply per prescription.**

*Revlimid® will be shipped to the patient by our Specialty Pharmacy.*

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Please **Print** Physician's Name & Specialty

\_\_\_\_\_  
Phone Number                      /                      Fax Number

Thank you for your assistance and should you have any questions or wish to discuss, please feel free to contact the pharmacy department at (501) 378-3392. For your convenience, you may fax your response(s) back to (501) 378-6980.

*Forms are also available online at [www.usableadmin.com/providers/PharmacyForms.aspx](http://www.usableadmin.com/providers/PharmacyForms.aspx)*