

PHYSICIAN PRIOR AUTHORIZATION REQUEST FORM BlueCross BlueShield of South Carolina

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

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

When this form is completed, please fax to Caremark at 1-888-836-0730.

This fax machine is located in a HIPAA-compliant, secure location. On behalf of BlueCross BlueShield of South Carolina, Caremark assists in the administration of prescription drug programs. Caremark is an independent company that provides pharmacy benefits management.

Call Caremark at 1-800-294-5979 with any questions concerning prior authorization procedures.

- | | | |
|--|----------------------------|----------------------------|
| 1. Is the patient currently on Revlimid therapy?
[If the answer to this question is yes, then no further questions required.] | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 2. Does the patient have a diagnosis of multiple myeloma?
[If the answer to this question is no, then may skip to question 7.] | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 3. Is the multiple myeloma classified as either relapsed or progressive?
[If the answer to this question is yes, then may skip to question 5.] | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 4. Will Revlimid be used in combination with dexamethasone?
[If the answer to this question is yes, then may sip to question 6.] | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 5. Is the patient a transplant candidate?
[If the answer to this question is yes, then no further questions.] | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 6. Will the patient be closely monitored for the signs and symptoms of thromboembolism on a regular basis?
[If the answer to this question is yes, then may skip to question 15.]
[If the answer is no, then no further questions required.] | <input type="checkbox"/> Y | <input type="checkbox"/> N |

PHYSICIAN PRIOR AUTHORIZATION REQUEST FORM BlueCross BlueShield of South Carolina

7. Does the patient have a diagnosis of anemia (e.g., pre-transfusion hemoglobin less than or equal to 10 mg/dL?
[If the answer to this question is no, then no further questions are required.] Y N
8. Is the anemia of the patient symptomatic due to low or intermediate-1 risk myelodysplastic syndrome associated with non-del(5q)?
[If the answer to this question is no, then skip to question 12.] Y N
9. Has the patient tried and failed to respond to initial therapy (e.g., recombinant human Epo, darbepoetin, hypomethylating agents or immunosuppressive therapy)?
[If the answer to this question is yes, then skip to question 15.] Y N
10. Does the patient have serum erythropoietin levels greater than 500 mU/mL?
[If the answer to this question is no, then no further questions are required.] Y N
11. Does the patient have a low probability of response to immunosuppressive therapy?
[If the answer to this question is yes, then skip to question 15.]
[If the answer is no, then no further questions are required.] Y N
12. Is the anemia of the patient due to Low- or Intermediate-1-risk myelodysplastic syndrome associated with a deletion 5q cytogenetic abnormality?
[If the answer to this question is no, then no further questions are required.] Y N
13. Is the anemia of the patient "transfusion-dependent" (e.g., the patient has received 2 or more units or red blood cells within the 8 weeks prior to therapy)?
[If the answer to this question is yes, then skip to question 15.] Y N
14. Does the patient have clinically significant cytopenia(s) as well?
[If the answer to this question is no, then no further questions are required.] Y N
15. Will the complete blood count (CBC) with differential and platelet counts of the patient be monitored on a regular basis?
[If the answer to this question is no, then no further questions are required.] Y N
16. Is the patient male?
[If the answer to this question is yes, then skip to question 19.] Y N
17. Is the patient female of childbearing potential?
[If the answer to this question is no, then no further questions are required.] Y N
18. Has pregnancy been excluded as confirmed by two negative urine or serum pregnancy tests?
[If the answer to this question is no, then no further questions are required.] Y N
19. Has the patient been instructed regarding the importance and the proper utilization of appropriate contraceptive methods for Revlimid use? Y N

Comments: _____

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

Prescriber's Signature:	Date:
--------------------------------	--------------