PriorityHealth

Pharmacy Prior Authorization Form

Fax completed form to: 877.974.4411 toll free, or 616.942.8206

This form applies to: ☒ **Commercial (Traditional)** ☒ **Commercial (Individual/Optimized)** ☐ **Medicaid**

This request is: ☐ **Urgent** (life threatening) ☐ **Non-Urgent** (standard review)

Urgent means the standard review time may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.

Pomalyst™ (pomalidomide)

Member

Last Name: _____ First Name: _____

ID #: _____ DOB: _____ Gender: _____

Primary Care Physician: _____

Requesting Provider: _____ Prov. Phone: _____ Prov. Fax: _____

Provider Address: _____

Provider NPI: _____ Contact Name: _____

Provider Signature: _____ Date: _____

Product and Billing Information

☐ New Request ☐ Continuation Request

Drug product:
- ☐ Pomalyst 1mg
- ☐ Pomalyst 2mg
- ☐ Pomalyst 3mg
- ☐ Pomalyst 4mg

Start date (or date of next dose): _____

Date of last dose (if applicable): _____

Dosing frequency: _____

Precertification Requirements

Before this drug is covered, the patient must meet all of the following requirements:

1. Diagnosis of multiple myeloma
    a. Failure of, or intolerance to at least two prior therapies including Revlimid® (lenalidomide) and Velcade® (bortezomib),
    b. Disease progression within 60 days of completion of the last therapy.
    c. Taken with low-dose dexamethasone, unless contraindicated or not tolerated
    d. If patient smokes, smoking cessation therapy will be tried
2. OR diagnosis of Kaposi sarcoma

- Quantity limit of 21 capsules every 28 days
- Coverage duration: 6 months

Note: Authorization for indications, dosing, or a route of administration not approved by the Food and Drug Administration (FDA) or recognized in CMS-accepted compendia (e.g. DrugDex, AHFS, U.S. Pharmacopeia, and also Clinical Pharmacology for oncology indications only) require supporting evidence for coverage. Please provide two published peer-reviewed literature articles supporting the appropriateness of the drug, the dosing of the drug, or the route of administration to be used for the identified indication.

All fields must be complete and legible for review. Your office will receive a response via fax. No changes made since 07/2020

Last reviewed 07/2020

Priority Health Precertification Documentation

A. What is the patient's diagnosis?

- ☐ Multiple myeloma
- ☐ Kaposi sarcoma

- ☐ Other: _____

Rationale for use: _____

B. For multiple myeloma only, does the patient have prior use of Revlimid and Velcade?

- ☐ Yes
- ☐ No – rationale for use: _____

C. For multiple myeloma only, does the patient have disease progression within 60 days from completion of the last therapy?

- ☐ Yes
- ☐ No – rationale for use: _____

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