Priority Health Medicare prior authorization form

Fax completed form to: 877.974.4411 toll free, or 616.942.8206

This form applies to: ☐ **Medicare Part B** ☒ **Medicare Part D**
This request is: ☐ **Expedited request** ☐ **Standard request**

Your request will be expedited if you haven't gotten the prescription and Priority Health Medicare determines, or your prescriber tells us, that your life or health may be at risk by waiting.

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: _____

Drug information

☐ New request ☐ Continuation request

Start date (or date of next dose): _____
Date of last dose (if applicable): _____

Drug Product ☐ Pomalyst oral capsule

Dosing frequency: _____

Prior authorization criteria

The following requirements need to be met before this drug is covered by Priority Health Medicare. These requirements have been approved by the Centers for Medicare and Medicaid Services (CMS), but you may ask us for an exception if you believe one or more of these requirements should be waived.

1. Must be used for a medically accepted indication*

Medically accepted indication*

This drug is only covered under Medicare Part D when it is used for a medically accepted indication. A medically accepted indication for a drug or biologic used in an anti-cancer chemotherapeutic regimen is a use that is *either*:

- approved by the Food and Drug Administration. (That is, the Food and Drug Administration has approved the drug for the diagnosis or condition for which it is being prescribed.)
- supported by one of the following references (known as compendia): National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium, Micromedex DrugDex, American Hospital Formulary Service-Drug Information, Clinical Pharmacology, or Lexi-Drugs
- — *or* — supported in peer-reviewed medical literature appearing in regular editions of approved publications

Additional information

Note: When coverage criteria are met, coverage duration is 1 year. Pomalyst is limited to 21 capsules every 28 days.

All fields must be complete and legible for review. Your office will receive a response via fax. No changes made since 01/2018
Last reviewed 10/2020

PriorityHealth

Priority Health Precertification Documentation

A. What is the patient's diagnosis?

☐ Multiple myeloma

1. **Is Pomalyst being used with dexamethasone?**
   - ☐ Yes
   - ☐ No. **Are you requesting an exception to the criteria?**
     - ☐ Yes. ***Rationale for exception***: _____
     - ☐ No

2. **Has the patient received at least 2 prior therapies and had disease progression within 60 days of the completing the last therapy?**
   - ☐ Yes
   - ☐ No. **Are you requesting an exception to the criteria?**
     - ☐ Yes. ***Rationale for exception***: _____
     - ☐ No

3. **Has the patient tried and progressed on lenalidomide (Revlimid)?**
   - ☐ Yes
   - ☐ No. **Are you requesting an exception to the criteria?**
     - ☐ Yes. ***Rationale for exception***: _____
     - ☐ No

4. **Has the patient tried and progressed on a proteasome inhibitor (e.g., Velcade)?**
   - ☐ Yes
   - ☐ No. **Are you requesting an exception to the criteria?**
     - ☐ Yes. ***Rationale for exception***: _____
     - ☐ No

☐ AIDS-related Kaposi sarcoma in an adult

1. **Has the patient failed highly active antiretroviral therapy (HAART)?**
   - ☐ Yes
   - ☐ No. **Are you requesting an exception to the criteria?**
     - ☐ Yes. ***Rationale for exception***: _____
     - ☐ No

2. **Is the patient HIV-negative?**
   - ☐ Yes
   - ☐ No. **Are you requesting an exception to the criteria?**
     - ☐ Yes. ***Rationale for exception***: _____
     - ☐ No

☐ *Other – the patient's condition is:* _____
Rationale for Other use: _____

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Priority Health Medicare Exception Request *(exceptions to the above criteria)*

Do you believe one or more of the prior authorization requirements should be waived? ☐ Yes ☐ No
If yes, you must provide a statement explaining the medical reason why the exception should be approved.

Would Pomalyst likely be the most effective option for this patient?
☐ No
☐ Yes, because:_____

_____

_____

If the patient is currently using Pomalyst, would changing the patient's current regimen likely result in adverse effects for the patient?
☐ No
☐ Yes, because:_____

_____

_____

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