

US Family Health Plan

Prior Authorization Request Form for pomalidomide (**Pomalyst**)

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD.

The completed form may be **faxed** to **617-562-5296**

OR

The patient may attach the completed form to the prescription and **mail** it to:

Attn: Pharmacy, 77 Warren St, Brighton, MA 02135

QUESTIONS? **Call 1-877-880-7007**

Step 1 Please complete patient and physician information (please print):

Patient Name: _____ Address: _____ _____ Sponsor ID #: _____ Date of Birth: _____	Physician Name: _____ Address: _____ _____ Phone #: _____ Secure Fax #: _____
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Step 2 Please complete the clinical assessment:

1. Is the patient GREATER THAN or EQUAL to 18 years of age?	<input type="checkbox"/> Yes Proceed to question 2	<input type="checkbox"/> No STOP Coverage not approved
2. Is the requested medication being prescribed by or in consultation with a hematologist or oncologist?	<input type="checkbox"/> Yes Proceed to question 3	<input type="checkbox"/> No STOP Coverage not approved
3. Does the patient have a diagnosis of relapsed/refractory multiple myeloma that is refractory to lenalidomide?	<input type="checkbox"/> Yes Proceed to question 6	<input type="checkbox"/> No Proceed to question 4
4. Is the indication for use myelofibrosis refractory to or with contraindications to alternative therapies (including lenalidomide) and erythropoietin levels greater than 500 mU/ml?	<input type="checkbox"/> Yes Proceed to question 9	<input type="checkbox"/> No Proceed to question 5
5. Is the indication for use systemic light chain amyloidosis with organ involvement refractory to or with contraindications to alternative therapies including lenalidomide?	<input type="checkbox"/> Yes Proceed to question 9	<input type="checkbox"/> No Proceed to question 10
6. Has the patient previously had a trial of a bortezomib, carfilzomib, OR regimen containing Ninlaro?	<input type="checkbox"/> Yes Proceed to question 7	<input type="checkbox"/> No STOP Coverage not approved
7. Will the patient be starting Pomalyst as a third (or higher) line of therapy?	<input type="checkbox"/> Yes Proceed to question 8	<input type="checkbox"/> No STOP Coverage not approved

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8. Will Pomalyst be used in combination with dexamethasone?	<input type="checkbox"/> Yes Proceed to question 9	<input type="checkbox"/> No STOP Coverage not approved
9. Is the patient taking Pomalyst along with lenalidomide or thalidomide?	<input type="checkbox"/> Yes STOP Coverage not approved	<input type="checkbox"/> No Sign and date below
10. Please provide the diagnosis.	<hr style="width: 80%; margin: 0 auto;"/> Proceed to question 11	
11. Is the diagnosis cited in the National Comprehensive Cancer Network (NCCN) guidelines as a category 1, 2A, or 2B recommendation?	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> No STOP Coverage not approved

Step 3 I certify the above is true to the best of my knowledge. Please sign and date:

Prescriber Signature

Date