

**USFHP 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 855-273-5735

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

<https://www.usfamilyhealth.org/for-providers/pharmacy-information/>

Prior authorization does not expire. Clinical documentation may be required

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

1	Patient Name: _____	Physician Name: _____
	Address: _____	Address: _____
	Sponsor ID # _____	Phone #: _____
	Date of Birth: _____	Secure Fax #: _____

Step 2 Please complete the clinical assessment:

1. Is the patient 18 years of age or older?	<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. What is the diagnosis or indication?	<input type="checkbox"/> Relapsed/refractory multiple myeloma that is refractory to lenalidomide - Proceed to question 4 <input type="checkbox"/> AIDS-related Kaposi sarcoma after failure of highly active antiretroviral therapy - Proceed to question 7 <input type="checkbox"/> Kaposi sarcoma AND is HIV-negative - Proceed to question 7 <input type="checkbox"/> Myelofibrosis refractory to or with contraindications to alternative therapies (including lenalidomide) and erythropoietin levels greater than or equal to 500 mU/ml - Proceed to question 7 <input type="checkbox"/> Systemic light chain amyloidosis with organ involvement refractory to or with contraindications to alternative therapies including lenalidomide - Proceed to question 7 <input type="checkbox"/> other diagnosis - Proceed to question 8	

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<p>4. Has the patient previously had a trial of a bortezomib, carfilzomib, OR regimen containing Ninlaro?</p>	<p align="center"><input type="checkbox"/> Yes Proceed to question 5</p>	<p align="center"><input type="checkbox"/> No STOP Coverage not approved</p>
<p>5. Will the patient be starting Pomalyst as a third (or higher) line of therapy?</p>	<p align="center"><input type="checkbox"/> Yes Proceed to question 6</p>	<p align="center"><input type="checkbox"/> No STOP Coverage not approved</p>
<p>6. Will Pomalyst be used in combination with dexamethasone?</p>	<p align="center"><input type="checkbox"/> Yes Proceed to question 7</p>	<p align="center"><input type="checkbox"/> No STOP Coverage not approved</p>
<p>7. Is the patient using concurrent lenalidomide or thalidomide with Pomalyst?</p>	<p align="center"><input type="checkbox"/> Yes STOP Coverage not approved</p>	<p align="center"><input type="checkbox"/> No Sign and date below</p>
<p>8. The diagnosis IS NOT listed above but IS cited in the National Comprehensive Cancer Network (NCCN) guidelines as a category 1, 2A, or 2B recommendation.</p> <p>To facilitate approval, please list the diagnosis, guideline version, and page number:</p>	<p align="center">_____</p> <p align="center">Sign and date below</p>	

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

_____ Prescriber Signature

_____ Date