Prescriber Criteria Form Pomalyst 2024 PA Fax 963-A v1 010124.docx Pomalyst (pomalidomide) Coverage Determination
This fax machine is located in a secure location as required by HIPAA regulations. Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673**. Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Pomalyst (pomalidomide).

Drug Name: Pomalyst (pomalidomide)

Patient Name:		
Patient ID:		
Patient DOB:	**Patient Phone:**	
Prescriber Name:		
Prescriber Address:		
City:	**State:**	**Zip:**
Prescriber Phone:	**Prescriber Fax:**	
Diagnosis:	**ICD Code(s):**	

Please circle the appropriate answer for each question.			
1	Does the patient have a diagnosis of multiple myeloma? [If no, then skip to question 5.]	Yes	No
2	Has the patient been previously treated for multiple myeloma with at least two prior therapies? [If no, then no further questions.]	Yes	No
3	Did one of these prior therapies contain an immunomodulatory agent? [If no, then no further questions.]	Yes	No
4	Did one of these prior therapies contain a proteasome inhibitor? [No further questions.]	Yes	No
5	Does the patient have a diagnosis of systemic light chain amyloidosis? [If no, then skip to question 7.]	Yes	No
6	Does the patient have relapsed/refractory disease? [No further questions.]	Yes	No
7	Does the patient have a diagnosis of primary central nervous system (CNS) lymphoma? [If yes, then no further questions.]	Yes	No
8	Does the patient have a diagnosis of Kaposi sarcoma and one of the following: A) Acquired immunodeficiency syndrome (AIDS), B) Human immunodeficiency virus (HIV)-	Yes	No

	negative? [If yes, no further questions.]		
9	Does the patient have a diagnosis of polyneuropathy, organomegaly, endocrinopathy, monoclonal protein, skin changes (POEMS) syndrome?	Yes	No

Comments:	___

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.

Prescriber (or Authorized) Signature: _______________________________ Date:___________________