Pomalyst

Prior Authorization Request

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-866-249-6155**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-866-814-5506.** For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

The recipient of this fax may make a request to opt-out of receiving telemarketing fax transmissions from CVS Caremark. There are numerous ways you may opt-out: The recipient may call the toll-free number at 877-265-2711, at any time, 24 hours a day/7 days a week. The recipient may also send an opt-out request via email to do_not_call@cvscaremark.com. An opt out request is only valid if it (1) identifies the number to which the request relates, and (2) if the person/entity making the request does not, subsequent to the request, provide express invitation or permission to CVS Caremark to send facsimile advertisements to such person/entity at that particular number. CVS Caremark is required by law to honor an opt-out request within thirty days of receipt.

Patient's Name: _____ **Date**: _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____
Request Initiated For: _____

ICD-10 Code: _____
Prescribed Drug and Dosage Form: _____
Is a loading dose required: ❑ Yes ❑ No
Prescribed Loading dose and duration: _____

Maintenance Dose and Frequency: _____

1. What is the patient's diagnosis?
   - ❑ Multiple myeloma
   - ❑ Systemic light chain amyloidosis
   - ❑ Kaposi sarcoma
   - ❑ Primary central nervous system lymphoma
   - ❑ POEMS (polyneuropathy, organomegaly, endocrinopathy, monoclonal protein, skin changes) Syndrome
   - ❑ Other _____
2. Is this a request for continuation of therapy with the requested drug? ❑ Yes ❑ No *If No, skip to #4*
3. Is there evidence of unacceptable toxicity or disease progression on the current regimen?
   ❑ Yes ❑ No *No further questions.*
4. If the patient's diagnosis is listed below, *skip to the indicated question.*
   - ❑ Multiple myeloma, *skip to #5*
   - ❑ Systemic light chain amyloidosis, *skip to #9*
   - ❑ Kaposi sarcoma, *skip to #11*
   - ❑ Primary central nervous system lymphoma, *skip to #14*
   - ❑ POEMS Syndrome, *skip to #15*
5. What is the prescribed regimen? *List continues on next page.*
   - ❑ The requested drug in combination with elotuzumab and dexamethasone
   - ❑ The requested drug in combination with ixazomib and dexamethasone
   - ❑ The requested drug in combination with bortezomib and dexamethasone
   - ❑ The requested drug in combination with cyclophosphamide and dexamethasone

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- ❑ The requested drug in combination with isatuximab-irfc and dexamethasone
- ❑ The requested drug in combination with dexamethasone
- ❑ The requested drug in combination with selinexor and dexamethasone
- ❑ The requested drug as a single agent
- ❑ The requested drug in combination with daratumumab and dexamethasone, *skip to #7*
- ❑ The requested drug in combination with carfilzomib and dexamethasone, *skip to #8*
- ❑ Other _____

6. Has the patient previously received at least two prior therapies including an immunomodulatory agent (e.g., Revlimid) and a proteasome inhibitor (e.g., Velcade) as treatment for multiple myeloma?
   ❑ Yes ❑ No *No further questions.*
7. Has the patient previously received at least one prior therapy including an immunomodulatory agent (e.g., Revlimid) and a proteasome inhibitor (e.g., Velcade) as treatment for multiple myeloma?
   ❑ Yes ❑ No *No further questions.*
8. Has the patient previously received at least one prior therapy for the treatment of multiple myeloma?
   ❑ Yes ❑ No *No further questions.*
9. What is the clinical setting in which the requested drug will be used?
   - ❑ Relapsed disease
   - ❑ Refractory disease
   - ❑ Other _____
10. Will the requested drug be used in combination with dexamethasone? ❑ Yes ❑ No *No further questions.*
11. Is the patient HIV-negative? *If Yes, no further questions.* ❑ Yes ❑ No
12. Does the patient have a diagnosis of AIDS-related Kaposi sarcoma? ❑ Yes ❑ No
13. Will the requested drug be used in combination with antiretroviral therapy?
    ❑ Yes ❑ No *No further questions.*
14. Will the requested drug be used as a single agent? ❑ Yes ❑ No *No further questions.*
15. Will the requested drug be used in combination with dexamethasone? ❑ Yes ❑ No

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X_____

Prescriber or Authorized Signature Date (mm/dd/yy)

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