Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.
Pomalidomide (Pomalyst) Prior Authorization (PA)
Pharmacy Benefits Prior Authorization Help Desk
Length of Authorizations: Initial- 12 months; Continuation- 12 months

Instructions:

This form is used by Kaiser Permanente and/or participating providers for coverage of **Pomalidomide (Pomalyst).** Please complete and fax this form back to Kaiser Permanente within 24 hours [fax: 1-866-331-2104]. If you have any questions or concerns, please call 1-866-331-2103. **Requests will not be considered unless this form is complete. The KP-MAS Formulary can be found at:** **http://pithelp.appl.kp.org/MAS/formulary.html**

1 – Patient Information

Patient Name: ______________________________ Kaiser Medical ID#: _________________ Date of Birth: _____________

2 – Provider Information

Prescriber specialty: □ Hematologist □ Oncologist □ Other: ____

If consulted with a specialist, specialist name and specialty: ____

Provider Name: ______________________________ Provider NPI: ____________________________

Provider Address: ____

Provider Phone #: __________________________Provider Fax #: ___________________________

Please check the boxes that apply:

□ Initial Request □ Continuation of Therapy Request

3 – Pharmacy Information

Pharmacy Name: ________________________________ Pharmacy NPI: ____

Pharmacy Phone #_______________________________ Pharmacy Fax #: ____

4 – Drug Therapy Requested

Drug 1: Name/Strength/Formulation: ____

Sig: ____

Drug 2: Name/Strength/Formulation: ____

Sig: ____

5 – Diagnosis

Please select Indication:
□ Multiple Myeloma
□ Other: ____

6–Clinical Criteria

Initial Therapy:

1. Does the member have a diagnosis of Multiple Myeloma with all the following?
   a) Using Pomalidomide (Pomalyst) in combination with dexamethasone
      □ No □ Yes
   b) Relapsed or refractory disease
      □ No □ Yes
   c) Treatment within the past 60 days
      □ No □ Yes
   d) History of failure, contraindication, or intolerance to at least 2 prior therapies, including lenalidomide and a proteasome inhibitor (e.g. bortezomib, carfilzomib).
      □ No □ Yes

Continuation of Therapy:

1. Member does NOT show evidence of progressive disease while on therapy
   □ No □ Yes

7 – Provider Sign-Off

Additional Information – Please provide any additional information that should be taken into consideration.
____

I certify that the information provided is accurate. Supporting documentation is available for State audits.

Provider Signature:	**Date:**
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