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

JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE
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FAX Completed Form and Applicable Progress Notes to: (410) 424-4037

USFHP Pharmacy Prior Authorization Form

To be completed by Requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

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

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 GREATER THAN or EQUAL to 18 years of age?	☐ Yes Proceed to question **2**	☐ No **STOP** **Coverage not approved**
2. Is the requested medication being prescribed by or in consultation with a hematologist or oncologist?	☐ Yes Proceed to question **3**	☐ No **STOP** **Coverage not approved**
3. Does the patient have a diagnosis of relapsed/refractory multiple myeloma that is refractory to lenalidomide?	☐ Yes Proceed to question **6**	☐ 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?	☐ Yes Proceed to question **9**	☐ 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?	☐ Yes Proceed to question **9**	☐ No Proceed to question **10**
6. Has the patient previously had a trial of a bortezomib, carfilzomib, OR regimen containing Ninlaro?	☐ Yes Proceed to question **7**	☐ No **STOP** **Coverage not approved**
7. Will the patient be starting Pomalyst as a third (or higher) line of therapy?	☐ Yes Proceed to question **8**	☐ No **STOP** **Coverage not approved**

8. Will Pomalyst be used in combination with dexamethasone?	☐ Yes Proceed to question **9**	☐ No **STOP** **Coverage not approved**
9. Is the patient taking Pomalyst along with lenalidomide or thalidomide?	☐ Yes **STOP** **Coverage not approved**	☐ No **Sign and date below**
10. Please provide the diagnosis.	_____ 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?	☐ Yes **Sign and date below**	☐ 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

[14 August 2019]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: