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| Prior Authorization |
| JOHNS HOPKINS HEALTHCARE (MEDICAID) Pomalyst - Priority Partners MCO |
| This fax machine is located in a secure location as required by HIPAA regulations. Complete/review information, sign and date. Fax signed forms to Johns Hopkins Healthcare at 1-410-424-4607 . Please contact Johns Hopkins Healthcare at 1-888-819-1043 with questions regarding the Prior Authorization process. |
| When conditions are met, we will authorize the coverage of Pomalyst - Priority Partners MCO. |

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| Drug Name (select from list of drugs shown) Pomalyst (pomalidomide) |
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|-------------------------|----------------------------|----------|
| Quantity | Frequency | Strength |
| Route of Administration | Expected Length of Therapy | |

| | |
|---------------------|-------|
| Patient Information | |
| Patient Name: | _____ |
| Patient ID: | _____ |
| Patient Group No.: | _____ |
| Patient DOB: | _____ |
| Patient Phone: | _____ |

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|-----------------------|-------|
| Prescribing Physician | |
| Physician Name: | _____ |
| Physician Phone: | _____ |
| Physician Fax: | _____ |
| Physician Address: | _____ |
| City, State, Zip: | _____ |

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|-------------------------|------------------------|
| Diagnosis: _____ | ICD Code: _____ |
|-------------------------|------------------------|

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| Comments: _____ |
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| Please circle the appropriate answer for each question. | |
| 1. Has the plan authorized this medication in the past for this patient (i.e., previous authorization is on file under this plan)? | <input type="checkbox"/> Y <input type="checkbox"/> N |
| NOTE: The use of physician samples, or manufacturer product discounts, does not guarantee coverage under the provisions of the medical and/or pharmacy benefit. All pertinent criteria must be met in order to be eligible for benefit coverage. | |
| [If yes, skip to question 9.] | |
| 2. Does the patient have a diagnosis of multiple myeloma? | <input type="checkbox"/> Y <input type="checkbox"/> N |
| NOTE: Submission of medical records is required | |

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| [If no, no further questions.] | |
| 3. Will the requested drug be used concurrently with dexamethasone? | <input type="checkbox"/> Y <input type="checkbox"/> N |
| NOTE: Submission of medical records is required | |
| [If no, no further questions.] | |
| 4. Will the patient receive concurrent aspirin, warfarin or low molecular weight heparin due to the high risk of thromboembolism? | <input type="checkbox"/> Y <input type="checkbox"/> N |
| NOTE: Submission of medical records is required | |
| [If yes, skip to question 6.] | |
| 5. Does the patient have absolute contraindication to antithrombotic therapy? | <input type="checkbox"/> Y <input type="checkbox"/> N |
| NOTE: Submission of medical records is required | |
| [If no, no further questions.] | |
| 6. Does the patient have a documented trial and failure of at least two prior therapies including Revlimid (lenalidomide) and a proteasome inhibitor (e.g. Velcade[bortezomib]) with disease progression on or within 60 days of completion of the last therapy? | <input type="checkbox"/> Y <input type="checkbox"/> N |
| NOTE: Submission of medical records is required | |
| [If no, no further questions.] | |
| 7. Is the patient 18 years of age or older? | <input type="checkbox"/> Y <input type="checkbox"/> N |
| [If no, no further questions.] | |
| 8. Will the requested drug be given at the guideline-recommended dosage? | <input type="checkbox"/> Y <input type="checkbox"/> N |
| [No further questions.] | |
| 9. Will the requested drug be given at an efficient dose to maximize patient adherence and cost-effective therapy? | <input type="checkbox"/> Y <input type="checkbox"/> N |
| NOTE: Submission of medical records is required | |

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

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| Prescriber (Or Authorized) Signature and Date |