

**OPTIMA HEALTH COMMUNITY CARE
AND
OPTIMA FAMILY CARE
(MEDICAID)**

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request. All other information may be filled in by office staff; fax to **1-800-750-9692**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. Incomplete form will delay authorization process.

Drug Requested: **Pomalyst®** (pomalidomide)

DRUG INFORMATION: Complete information below. If incomplete, authorization process will be delayed.

Drug Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy:** _____

Diagnosis: _____ **ICD Code, if applicable:** _____

RECOMMENDED DOSAGE: 4mg per day taken orally on days 1-21 of repeated 28-day cycles until disease progression.

CLINICAL CRITERIA: Complete below to ensure authorization will **NOT** be delayed if **all** boxes are **not** checked.

Patient has a diagnosis of multiple myeloma which has progressed **within 60 days** of last therapy

AND

Patient has failed therapy with Revlimid®

AND

Patient has failed therapy with Velcade®

Medication being provided by a Specialty Pharmacy - PropriumRx

****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.****

Previous therapies will be verified through pharmacy paid claims or submitted chart notes.

Patient Name: _____

Member Optima #: _____ Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

DEA OR NPI #: _____