OPTIMA HEALTH PLAN

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 DOSING: Pomalyst® dosage is 4mg per day taken orally on days 1-21 of repeated 28-day cycles until disease progression.

CLINICAL CRITERIA: ALL boxes MUST be checked to qualify. Incomplete information will delay authorization process.

- ❑ 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 #: _____

***Approved by Pharmacy and Therapeutics Committee:** 7/18/2013
REVISED/UPDATED: 9/30/2013; 8/13/2014; 9/23/2014; 11/2/2014; 5/22/2015; 12/28/2015; 9/22/2016; 12/11/2016; **8/4/2017**