Prescriber Criteria Form

Pomalyst 2025 PA Fax 963-A v1 010125.docx
Pomalyst (pomalidomide)
Coverage Determination

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673.** Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Pomalyst (pomalidomide).

Drug Name:
Pomalyst (pomalidomide)

Patient Name:		
Patient ID:		
Patient DOB:	**Patient Phone:**	
Prescriber Name:		
Prescriber Address:		
City:	**State:**	**Zip:**
Prescriber Phone:	**Prescriber Fax:**	
Diagnosis:	**ICD Code(s):**	

Please circle the appropriate answer for each question.			
1	Does the patient have a diagnosis of multiple myeloma? [If no, then skip to question 3.]	Yes ◯	No ◯
2	Has the patient been previously treated for multiple myeloma with at least two prior therapies, including an immunomodulatory agent and a proteasome inhibitor? [No further questions.]	Yes ◯	No ◯
3	Does the patient have a diagnosis of systemic light chain amyloidosis? [If no, then skip to question 5.]	Yes ◯	No ◯
4	Does the patient have relapsed/refractory disease? [No further questions.]	Yes ◯	No ◯
5	Does the patient have a diagnosis of primary central nervous system (CNS) lymphoma? [If yes, then no further questions.]	Yes ◯	No ◯
6	Does the patient have a diagnosis of Kaposi sarcoma? [If yes, then no further questions.]	Yes ◯	No ◯
7	Does the patient have a diagnosis of polyneuropathy, organomegaly, endocrinopathy, monoclonal protein, skin changes (POEMS) syndrome?	Yes ◯	No ◯

Comments:	_____

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.
Prescriber (or Authorized) Signature: _____ Date:_____