CVS caremark™ {{PANUMCODE}}

Pomalyst

Prior Authorization Request

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-866-249-6155**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-866-814-5506.** For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

The recipient of this fax may make a request to opt-out of receiving telemarketing fax transmissions from CVS Caremark. There are numerous ways you may opt-out: The recipient may call the toll-free number at 877-265-2711, at any time, 24 hours a day/7 days a week. The recipient may also send an opt-out request via email to do_not_call@cvscaremark.com. An opt out request is only valid if it (1) identifies the number to which the request relates, and (2) if the person/entity making the request does not, subsequent to the request, provide express invitation or permission to CVS Caremark to send facsimile advertisements to such person/entity at that particular number. CVS Caremark is required by law to honor an opt-out request within thirty days of receipt.

Patient's Name: {{MEMFIRST}} {{MEMLAST}} **Date**: {{TODAY}}
Patient's ID {{MEMBERID}} **Patient's Date of Birth:** {{MEMBERDOB}}
Physician's Name: {{PHYFIRST}} {{PHYLAST}}
Specialty: _____, NPI#: _____
Physician Office Telephone: {{PHYSICIANPHONE}} **Physician Office Fax:** {{PHYSICIANFAX}}
Request Initiated For: {{DRUGNAME}}

1. What is the patient's diagnosis?
   - ❑ Multiple myeloma
   - ❑ Kaposi sarcoma
   - ❑ Systemic light chain amyloidosis
   - ❑ Primary central nervous system lymphoma
   - ❑ Other _____

2. What is the ICD-10 code? _____

3. Is this a request for continuation of therapy with the requested drug?
   ❑ Yes ❑ No *If No, skip to diagnosis section*

4. Is there evidence of unacceptable toxicity or disease progression on the current regimen?
   ❑ Yes ❑ No *No further questions*

Complete the following section based on the patient's diagnosis, if applicable.

Section A: Multiple Myeloma

5. How many different treatment therapies has the patient previously received (not including the requested therapy)?
   _____ therapies

6. Has the patient previously received an immunomodulatory agent and a proteasome inhibitor as treatment for multiple myeloma? ❑ Yes ❑ No

7. What is the prescribed regimen?
   - ❑ Pomalyst in combination with daratumumab and dexamethasone
   - ❑ Pomalyst in combination with elotuzumab and dexamethasone
   - ❑ Pomalyst in combination with ixazomib and dexamethasone
   - ❑ Pomalyst in combination with bortezomib and dexamethasone
   - ❑ Pomalyst in combination with carfilzomib and dexamethasone
   - ❑ Pomalyst in combination with cyclophosphamide and dexamethasone
   - ❑ Pomalyst in combination with isatuximab-irfc and dexamethasone
   - ❑ Pomalyst in combination with dexamethasone
   - ❑ Pomalyst as a single agent
   - ❑ Other _____

Send completed form to: Case Review Unit, CVS Caremark Prior Authorization Fax: 1-866-249-6155

Section B: Systemic Light Chain Amyloidosis

8. Is this request for relapsed or refractory disease? ❑ Yes ❑ No

9. Will Pomalyst be used in combination with dexamethasone? ❑ Yes ❑ No

Section C: Kaposi Sarcoma

10. Is the patient HIV-negative? *If Yes, no further questions* ❑ Yes ❑ No

11. Does the patient have a diagnosis of AIDS-related Kaposi sarcoma? ❑ Yes ❑ No

12. Will Pomalyst be used in combination with antiretroviral therapy? ❑ Yes ❑ No

Section D: Primary CNS Lymphoma

13. Is this request for relapsed or refractory disease? ❑ Yes ❑ No

14. Will Pomalyst be used as a single agent? ❑ Yes ❑ No

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X_____

Prescriber or Authorized Signature **Date (mm/dd/yy)**

Send completed form to: Case Review Unit, CVS Caremark Prior Authorization Fax: 1-866-249-6155