BlueCross BlueShield Federal Employee Program

POMALYST
PRIOR APPROVAL REQUEST

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

Patient Information (required)			**Provider Information (required)**		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		
PHYSICIAN COMPLETES					

Pomalyst (pomalidomide)

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

NOTE: Form must be completed in its **entirety** for processing

1. Has the patient been on Pomalyst continuously for the last **6 months**, excluding samples? ***Please select answer below:***
   ❑**YES -** this is a PA renewal for **CONTINUATION** of therapy, please answer the questions on **PAGE 2**
   ❑**NO –** this is **INITIATION** of therapy, please answer the questions below:
2. Is this request for brand or generic? ❑Brand ❑Generic
3. How many capsules will the patient need for an 84 day supply? _____ capsule(s) per 84 days
4. What is the patient's diagnosis?
   ❑Kaposi Sarcoma (KS)
      a. Does the patient have AIDS-related Kaposi sarcoma? ***Please select answer below:***
         ❑**Yes**: Has the patient failed highly active antiretroviral therapy (HAART)? ❑Yes ❑No
         ❑**No**: Is the patient HIV-negative? ❑Yes ❑No
   ❑Multiple myeloma
      a. Has the patient received at least two prior therapies which included lenalidomide (Revlimid) and a proteasome inhibitor? ***Please select answer below:***
         ❑**Yes**: Has the patient had disease progression on or within 60 days of completion of the last therapy for multiple myeloma? ❑Yes ❑No
         ❑**No**: Has the patient received at least one prior therapy which included lenalidomide (Revlimid) and a proteasome inhibitor? ❑Yes ❑No
      b. Will Pomalyst be used in combination with daratumumab and hyaluronidase-fihj (Darzalex Faspro)? ❑Yes ❑No
      c. Will Pomalyst be used with dexamethasone? ❑Yes ❑No
   ❑Other diagnosis ***(please specify)***: _____
5. Will the patient's blood counts for neutropenia, thrombocytopenia, and anemia be monitored weekly for the first eight weeks of therapy and monthly thereafter? ❑Yes ❑No
6. Are the physician, patient, and pharmacy enrolled in the Pomalyst REMS program? ❑Yes ❑No
7. **FEMALE Patient**: Is the patient of reproductive potential? ❑Yes***** ❑No
   ****If YES***, please answer the following questions:
      a. Has or will pregnancy be excluded prior to the start of therapy? ❑Yes ❑No
      b. Will the patient be advised to use two reliable methods of contraception during treatment with Pomalyst and for four weeks after the last dose? ❑Yes ❑No
8. **MALE Patient**: Does the patient have a female partner of reproductive potential? ❑Yes***** ❑No
   ****If YES***, will the patient be advised to use a latex or synthetic condom during treatment with Pomalyst and for four weeks after the last dose, even if they have undergone a successful vasectomy? ❑Yes ❑No

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Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		
PHYSICIAN COMPLETES					

CONTINUATION OF THERAPY (PA RENEWAL)

Pomalyst (pomalidomide)

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

NOTE: Form must be completed in its **entirety** for processing

1. Has the patient been on Pomalyst continuously for the last **6 months**, excluding samples? ***Please select answer below:***
   ❑**NO –** this is **INITIATION** of therapy, please answer the questions on **PAGE 1**
   ❑**YES -** this is a PA renewal for **CONTINUATION** of therapy, please answer the questions below:

2. Is this request for brand or generic? ❑Brand ❑Generic

3. How many capsules will the patient need for an 84 day supply? _____ capsule(s) per 84 days

4. What is the patient's diagnosis?
   - ❑ Kaposi Sarcoma (KS)
   - ❑ Multiple myeloma
   - ❑ Other diagnosis ***(please specify)***: _____

5. Will the patient's blood counts for neutropenia, thrombocytopenia, and anemia be monitored monthly? ❑Yes ❑No

6. **FEMALE Patient**: Is the patient of reproductive potential? ❑Yes***** ❑No
   ***If YES**, will the patient be advised to use two reliable methods of contraception during treatment with Pomalyst and for four weeks after the last dose? ❑Yes ❑No

7. **MALE Patient**: Does the patient have a female partner of reproductive potential? ❑Yes***** ❑No
   ***If YES**, will the patient be advised to use a latex or synthetic condom during treatment with Pomalyst and for four weeks after the last dose, even if they have undergone a successful vasectomy? ❑Yes ❑No

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Message:

Attached is a Prior Authorization request form.

For your convenience, there are 3 ways to complete a Prior Authorization request:

Electronically Online (ePA) Results in 2-3 **minutes** **FASTEST AND EASIEST**	Now you can get responses to drug Prior Authorization requests **securely** online. **Online** submissions may receive **instant** responses and do not require faxing or phone calls. Requests can be made 24 hours a day, 7 days a week. For more information on electronic prior authorization (ePA) and to register, go to **Caremark.com/ePA.**
Phone (4-5 **minutes** for response)	The FEP Clinical Call Center can be reached at **(877)-727-3784** between the hours of 7AM-9PM Eastern Time. A live representative will assist with the Prior Authorization, asking for the same information contained on the attached form. Please review the form and have your answers ready for faster service. The process over the phone takes on average between 4 and 5 minutes.
Fax (3-5 **days** for response)	Fax the attached form to **(877)-378-4727**. Requests sent via fax will be processed and responded to within 5 business days. The form must be filled out completely, if there is any missing information the Prior Authorization request cannot be processed. ***Please only fax the completed form once as duplicate submissions may delay processing times.***