Prescriber Criteria Form Pomalyst 2026 PA Fax 963-A v1 010126.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	Did the patient receive 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?	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:_____