Pomalyst

Express Scripts
Prior Authorization
Phone 1-844-424-8886
Fax 1-877-251-5896

To start your Part D Coverage Determination request, you (or your representative or your doctor or other prescriber) should contact Express Scripts, Inc (ESI):

- You may Call ESI at 1-844-424-8886, 24 hours a day, 7 days a week,
  TTY users: 1-800-716-3231
- You may Fax your request to: 1-877-251-5896 (Attention: Medicare Reviews)
- You may also send your request via email to: medicarepartdparequests@express-scripts.com

Member's Last Name:	Member's First Name:
SCAN ID number:	Date of Birth:
Prescriber's Name:	Contact Person:
Office phone:	Office Fax:

Medication:	Diagnosis:

SECTION A Please answer the following questions

1.	θ Yes	θ No	Is the member currently taking the requested medication?
2.	θ Yes	θ No	Is the diagnosis for the treatment of AIDS-related Kaposi sarcoma (KS) after failure of highly active antiretroviral therapy (HAART) or in patients with KS who are HIV-negative?
3.	θ Yes	θ No	Is the diagnosis for the treatment of multiple myeloma?
4.	θ Yes	θ No	Has the member received at least two prior therapies including lenalidomide and bortezomib and demonstrated disease progression on or within 60 days of completion of the last therapy?
5.	θ Yes	θ No	Is the prescription written or recommended by an Oncologist?
6.	θ Yes	θ No	Is the member pregnant?
7.	θ Yes	θ No	Is the member a female of reproductive potential?
8.	θ Yes	θ No	Will two reliable methods of contraception be used while taking Pomalyst if member is a female of reproductive potential?
9.	θ Yes	θ No	Does the member have underlying risk factors for deep vein thrombosis or pulmonary embolism?
10	θ Yes	θ No	Has anti-coagulation prophylaxis been considered in a member who has underlying risk factors for deep vein thrombosis or pulmonary embolism?
11	θ Yes	θ No	Is the absolute neutrophil count greater than or equal to 500 per microliter?

12. θ Yes θ No Is the platelet count greater than or equal to 50,000 per microliter?
13. θ Yes θ No Is the serum creatinine less than or equal to 3.0 mg/dL?
14. θ Yes θ No Is the serum bilirubin less than or equal to 2.0 mg/dL?
15. θ Yes θ No Is the AST/ALT less than or equal to three times the upper limit of normal range?

Please document the symptoms and/or any other information important to this review:

SECTION B Physician Signature

PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 1-877-251-5896

Our response time for prescription drug coverage standard requests is 72 hours. If you or your prescriber believe that waiting 72 hours for a standard decision could seriously harm your life, health, or ability to regain maximum function, you can ask for an expedited (fast) decision. If your prescriber indicates that waiting 72 hours could seriously harm your health, we will automatically give you a decision within 24 hours. If you do not obtain your prescriber's support for an expedited request, we will decide if your case requires a fast decision. You cannot request an expedited coverage determination if you are asking us to pay you back for a drug you already received. View our formulary and Prior Authorization criteria online at http://www.villagehealthca.com