

Member Name: _____ **Date of Birth:** _____ **Member ID#:** _____

Drug Information

Physician billing (HCPCS code: _____ **) Start Date:** _____

Billing Provider Information

Provider NPI: _____ **Provider Name:** _____

Provider Phone: _____ **Provider Fax:** _____

Prescriber Information

Prescriber NPI: _____ **Prescriber Name:** _____

Prescriber Phone: _____ **Prescriber Fax:** _____ **Specialty:** _____

Criteria

For Authorization:

1. Please include the most recent office visit note or clinical summary from the hospital to support your request. Is this information attached? Yes ___ No ___
2. Is the health care facility on the certified list to administer chimeric antigen receptor (CAR) T-cells? Yes ___ No ___
3. Is the health care facility trained in the management of cytokine release syndrome (CRS) and neurologic toxicities? Yes ___ No ___
4. Will the health care facility comply with the Abecma[®] risk evaluation and mitigation strategy (REMS) program requirements? Yes ___ No ___
5. Please indicate the diagnosis and information:
 - Multiple Myeloma**
 - A. Is disease status relapsed or refractory? Yes ___ No ___
 - B. Has member received at least 4 lines of prior therapy including an immunomodulatory agent, a proteasome inhibitor, and an anti-CD38 monoclonal antibody? Yes ___ No ___
 - C. Please list therapies member has tried and failed:

 - i. For the therapies listed, did the member undergo at least 2 consecutive cycles of treatment for each regimen? Yes ___ No ___
 1. If no, please list therapies member received for less than 2 consecutive cycles:

 - a. Was progressive disease seen after 1 cycle of each of these therapies? Yes ___ No ___
 - ii. Do the therapies listed include induction with or without autologous hematopoietic stem cell transplant with or without maintenance therapy? Yes ___ No ___
 - D. Does the member have measurable disease as evidenced by at least 1 of the following? Yes ___ No ___
 Please check all that apply:

___ Urine M-protein ≥200mg/24hr ___ Bone marrow plasma cells >30% of total bone marrow cells
 ___ Serum M-protein ≥0.5g/dL ___ Serum free light chain (FLC) assay: involved FLC ≥10mg/dL (100mg/L)
 - E. Does the member have central nervous system involvement with multiple myeloma? Yes ___ No ___
 - If answer is none of the above, please indicate diagnosis:** _____

Prescriber Signature: _____ **Date:** _____

I certify that the indicated treatment is medically necessary and all information is true and correct to the best of my knowledge. Please do not send in chart notes. Specific information will be requested if necessary. Failure to complete this form in full and attach requested clinical notes will result in processing delays.

Fax completed prior authorization request form to **888-601-8461** or submit Electronic Prior Authorization through CoverMyMeds[®] or SureScripts. All requested data must be provided. Incomplete forms or forms without the chart notes will be returned. Pharmacy Coverage Guidelines are available at **AetnaBetterHealth.com/Oklahoma.**

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