OKLAHOMA Health Care Authority

State of Oklahoma SoonerCare

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Elrexfio™ (Elranatamab-bcmm) Prior Authorization Form

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

Drug Information

Physician billing (HCPCS code: _____***) Start Date (or date of next dose):*** _____

Dose: _____ ***Dosing Regimen:*** _____

Billing Provider Information

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

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

Prescriber Information

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

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

For Initial Authorization:

1. Please indicate the diagnosis and information:

☐ **Multiple Myeloma**

A. Is disease relapsed or refractory? Yes☐ No☐

B. Has the member received at least 4 prior lines of therapy, including a proteasome inhibitor, an immunomodulatory agent, and an anti-CD38 monoclonal antibody? Yes☐ No☐

☐ **If diagnosis is not listed above, please indicate diagnosis:** _____

Additional Information: _____

_____

For Continued Authorization:

1. Date of last dose: _____
2. Does member have any evidence of progressive disease while on elranatamab-bcmm therapy?
   Yes☐ No☐
3. Has member experienced any adverse drug reactions related to elranatamab-bcmm therapy?
   Yes☐ No☐

If yes, please specify adverse reactions: _____

Additional Information: _____

_____

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. *Failure to complete this form in full 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.**	