

Empliciti® (Elotuzumab) Prior Authorization Form

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

Drug Information

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

Dose: _____ Regimen: _____

Billing Provider Information

Provider NPI: _____ Provider Name: _____

Provider Phone: _____ Provider Fax: _____

Prescriber Information

Prescriber NPI: _____ Prescriber Name: _____

Prescriber Phone: _____ Prescriber Fax: _____ Specialty: _____

Criteria

For Initial Authorization

1. Please indicate the diagnosis and information

Multiple Myeloma

A. Is diagnosis previously treated multiple myeloma with relapsed or progressive disease?

Yes No

B. Will elotuzumab be used in combination with lenalidomide and dexamethasone after 1 to 3 prior therapies? Yes No

C. Will elotuzumab be used in combination with bortezomib and dexamethasone? Yes No

D. Will elotuzumab be used in combination with pomalidomide and dexamethasone after ≥ 2 prior therapies, including an immunomodulatory agent and a proteasome inhibitor (PI)? 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 elotuzumab? Yes No

3. Has the member experienced adverse drug reactions related to elotuzumab 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. Please do not send in chart notes. Specific information will be requested if necessary. 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**.

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