

Abecma[®] (idecabtagene vicleucel) Prior Authorization Form

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 a qualified treatment center 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. Please indicate the diagnosis and information:
 - Multiple Myeloma**
 - A. Is disease status relapsed or refractory? Yes No
 - B. Has member received at least 2 prior lines of 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 $\geq 200\text{mg}/24\text{hr}$ Bone marrow plasma cells $>30\%$ of total bone marrow cells
 Serum M-protein $\geq 0.5\text{g}/\text{dL}$ Serum free light chain (FLC) assay: involved FLC $\geq 10\text{mg}/\text{dL}$ ($100\text{mg}/\text{L}$)
 - 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.

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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