

Carvykti™ (ciltacabtagene autoleucel) 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 ≥ 1 line of prior therapy including an immunomodulatory agent and a proteasome inhibitor? Yes No
 - C. Is member refractory to lenalidomide? Yes No
 - D. 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
 - E. 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 ≥ 200 mg/24hr Bone marrow plasma cells $>30\%$ of total bone marrow cells
 Serum M-protein ≥ 0.5 g/dL Serum free light chain (FLC) assay: involved FLC ≥ 10 mg/dL (100mg/L)
 - F. 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. 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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