

Epkinly® (epcoritamab-bysp) 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:

 LymphomaA. Is diagnosis relapsed or refractory follicular lymphoma (FL) or diffuse large B-cell lymphoma (DLBCL) not otherwise specified, including DLBCL arising from indolent lymphomas and/or high-grade B-cell lymphomas? Yes No B. Has the member received 2 or more lines of systemic therapy? 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 epcoritamab-bysp therapy?

Yes No

3. Has member experienced any adverse drug reactions related to epcoritamab-bysp 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.**CONFIDENTIALITY NOTICE**

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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.