

Lynozytic™ (linvoseltamab-gcpt) 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 relapsed or refractory multiple myeloma? Yes No

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

C. Is health care facility trained in the management of cytokine release syndrome (CRS) and neurologic toxicities? Yes No

D. Will health care facility comply with the risk evaluation and mitigation strategy (REMS) requirements? Yes No

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

For Continued Authorization:

1. Date of last dose: _____

2. Does the member have any evidence of progressive disease while on Lynozytic™? Yes No

3. Has the member experienced any adverse drug reactions related to Lynozytic™ 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.

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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.