

**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 on the certified list 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. Will the health care facility comply with the Abecma® risk evaluation and mitigation strategy (REMS) program requirements? Yes ☐ No ☐
5. 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 ≥200mg/24hr
☐ Bone marrow plasma cells >30% of total bone marrow cells

☐ Serum M-protein ≥0.5g/dL
☐ Serum free light chain (FLC) assay: involved FLC ≥10mg/dL (100mg/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. Please do not send in chart notes. Specific information will be requested if necessary. Failure to complete this form in full and attach requested clinical notes 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.