OKLAHOMA Health Care Authority

State of Oklahoma
SoonerCare

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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 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 Carvykti™ 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 ≥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 ≥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)

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 requesteddata must be provided. Incomplete forms or forms without the chart notes will be returned. Pharmacy Coverage Guidelines are available at AetnaBetterHealth.com/Oklahoma.