peach state health plan

Telephone: (800) 514-0083 option 2
Fax: (866) 374-1579

Ciltacabtagene Autoleucel (Carvykti)
Prior Authorization Form/Prescription

Date: _____ Date Medication Required: _____
Ship to: ❍ Physician ❍ Patient's Home ❍ Other _____

Patient Information

*Last Name:	*First Name:	Middle:	*DOB: ____/____/_____
Address:	City:	State:	Zip:
Daytime Phone:	Evening Phone:	*Sex: ☐ Male	☐ Female

Insurance Information (*Attach copies of cards*)

*Primary Insurance:		Secondary Insurance:	
*ID #	Group #	ID #	Group #
City:	State:	City:	State:

Physician Information

*Name:	*Specialty:	NPI:	
Address:	City:	State:	Zip:
*Phone #:	Secure Fax #:	Office Contact:	

Procedural Hospital

*Hospital Name:

Primary Diagnosis

*ICD-10 Code: _____

☐Multiple myeloma (MM) ☐Other: _____

Prescription Information

MEDICATION	STRENGTH	*DIRECTIONS	QUANTITY	REFILLS
Carvykti (Ciltacabtagene Autoleucel)				

Clinical Information

***** *Please submit supporting clinical documentation* *****

***THERAPY TYPE (choose one):** ☐INITIAL THERAPY ☐CONTINUATION OF THERAPY - Therapy start date: _____

1. Is Carvykti prescribed by or in consultation with an oncologist or hematologist? ☐Yes ☐No
2. Please document patient's measurable disease (within the last 30 days) of at least 1 of the following: ***Mark all that apply***
   ☐Serum M-protein: _____g/dL Date tested: _____
   ☐Urine M-protein: _____mg/24 h Date tested: _____
   ☐Serum free light chain (FLC) assay: Date tested: _____
   _____mg/dL
   a. *If serum FCL*, is FLC ratio abnormal? ☐Yes ☐No
3. Does patient have active or prior history of either of the following involvement of MM? ☐Yes ***Mark all that apply*** ☐No
   ☐Central nervous system (CNS) (e.g., seizure, cerebrovascular ischemia) ☐Exhibit clinical signs of meningeal
4. Has patient previously received treatment with anti-BCMA targeted therapy (e.g., Blenrep)? ☐Yes ☐No
5. Has patient previously received treatment with CAR T-cell immunotherapy? ☐Yes ***Mark all that apply*** ☐No
   ☐Abecma ☐Breyanzi ☐Kymriah ☐Tecartus ☐Yescarta ☐Other: _____
6. Has patient received ≥ 4 prior lines of therapy with at least 1 proteasome inhibitor (PI), immunomodulatory drug (IMiD), and Anti-CD38 antibody? ☐Yes ***Mark all that apply*** ☐No
   ☐Bortezomib ☐Pomalyst ☐Bortezomib/dexamethasone ☐Pomalidomide/dexamethasone ☐Sarclisa (isatuximab-irfc)
   ☐Thalomid ☐VTD-PACE (dexamethasone/Thalomid (thalidomide)/cisplatin/doxorubicin/cyclophosphamide/etoposide/bortezomib)
   ☐Bendamustine/bortezomib/dexamethasone ☐Bortezomib/doxorubicin/dexamethasone ☐Kyprolis (carfilzomib)/dexamethasone
   ☐Panobinostat/bortezomib/dexamethasone ☐Ninlaro (ixazomib)/dexamethasone ☐Panobinostat/Kyprolis (carfilzomib)
   ☐Pomalidomide/bortezomib/dexamethasone ☐Revlimid (lenalidomide)/dexamethasone ☐Darzalex (daratumumab)
   ☐Darzalex Faspro (daratumumab/hyaluronidase-fihj)/bortezomib/dexamethasone ☐Ninlaro (ixazomib)

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Please continue to page 2.

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Patient Name: _____ **DOB:** _____

(continued from page 1)

- ☐ Darzalex Faspro (daratumumab/hyaluronidase-fihj)/bortezomib/melphan/prednisone
- ☐ Darzalex faspro (daratumumab/hyaluronidase-fihj)/pomalidomide/dexamethasone
- ☐ Darzalex Faspro (daratumumab/hyaluronidase-fihj)/Revlimid (lenalidomide)/dexamethasone
- ☐ Bendamustine/Revlimid (lenalidomide)/dexamethasone
- ☐ Bortezomib/cyclophosphamide/dexamethasone
- ☐ Bortezomib/liposomal doxorubicin/dexamethasone
- ☐ Bortezomib/Revlimid (lenalidomide)/dexamethasone
- ☐ Bortezomib/Thalomid (thalidomide)/dexamethasone
- ☐ Cyclophosphamide/Revlimid (lenalidomide)/dexamethasone
- ☐ Darzalex (daratumumab)/bortezomib/dexamethasone
- ☐ Darzalex (daratumumab)/bortezomib/melphan/prednisone
- ☐ Darzalex (daratumumab)/pomalidomide/dexamethasone
- ☐ Darzalex (daratumumab)/Revlimid (lenalidomide)/dexamethasone
- ☐ Darzalex Faspro (daratumumab/hyaluronidase-fihj)
- ☐ Empliciti (elotuzumab)/bortezomib/dexamethasone
- ☐ Kyprolis (carfilzomib)
- ☐ Revlimid (lenalidomide)
- ☐ Empliciti (elotuzumab)/pomalidomide/dexamethasone
- ☐ Empliciti (elotuzumab)/Revlimid (lenalidomide)/dexamethasone
- ☐ Kyprolis (carfilzomib)/cyclophosphamide/dexamethasone
- ☐ Kyprolis (carfilzomib)/Revlimid (lenalidomide)/dexamethasone
- ☐ Ninlaro (ixazomib)/pomalidomide/dexamethasone
- ☐ Ninlaro (ixazomib)/Revlimid (lenalidomide)/dexamethasone
- ☐ Panobinostat/Revlimid (lenalidomide)/dexamethasone
- ☐ Pomalidomide/cyclophosphamide/dexamethasone
- ☐ Pomalidomide/Kyprolis (carfilzomib)/dexamethasone
- ☐ Revlimid (lenalidomide)/low-dose dexamethasone
- ☐ Sarclisa (isatuximab-irfc)/pomalidomide/dexamethasone
- ☐ Other: _____

Complete this section ONLY for indications <u>other</u> than multiple myeloma:

7. Has patient tried and failed, or is contraindicated to, accepted standards of care? ☐Yes ☐No
   If yes, submit documentation and answer the following:*
   a. Please list all previous therapies: _____
   b. Was patient adherent to previously tried therapies? ☐Yes ☐No ☐No, patient intolerant to drug

Physician's Signature: _____ **Date:** _____ ☐DAW

INFORMATION BELOW IS TO BE COMPLETED BY THE HEALTH PLAN / CPS PA STAFF

Authorization Information

***Authorization number:**	***Decision Due Date:**
***J-Code:**	***Coverage:** ☐ State excludes ☐ COB (secondary)
***Line of Business:** ☐ Commercial ☐ Health Insurance Marketplace ☐ Medicaid ☐ Medicare	***Benefit:** ☐ Medical ☐ Pharmacy

***Criteria:**

☐ Centene Policy [**CP.PHAR.533 Ciltacabtagene Autoleucel (Carvykti)**]
What is the date the Centene policy was last reviewed/approved by plan (we want to be sure we are using the version approved by your plan): _____

☐ State or Health Plan specific (<u>please include policy</u>) _____

☐ Medicare Local Coverage Decision (LCD) specific for your region.
<u>Please include policy of link to LCD, followed by any applicable step therapy requirements.</u> _____

☐ Medicare National Coverage Decision (NCD) (please include policy of link to NCD)
<u>Please include policy of link to NCD, followed by any applicable step therapy requirements.</u> _____