JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE

Abecma

Prior Authorization Request

Your patient's benefit plan requires prior authorization for certain medications. In order to make appropriate medical necessity determinations, your patient's diagnosis and other clinical information is required. **Please complete the information requested on the form below and fax this form to Priority Partners, toll-free at 1-866-212-4756** to initiate the review process. If you have questions regarding the prior authorization please contact Priority Partners at 888-819-1043 Option 4**.**

Patient's Name: _____ **Date**: _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____

Referring Provider Info: ❑ Same as Requesting Provider
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Rendering Provider Info: ❑ Same as Referring Provider ❑ Same as Requesting Provider
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Required Demographic Information:

Patient Weight: _____*kg*

Patient Height: _____*cm*

Please indicate the place of service for the requested drug:

❑ *Ambulatory Surgical* ❑ *Home* ❑ *Off Campus Outpatient Hospital*
❑ *On Campus Outpatient Hospital* ❑ *Office*

Drug Information:

Strength/Measure _____ *Units* ❑ ml ❑ Gm ❑ mg ❑ ea ❑ Un
Directions(sig) _____ *Route of administration* _____
Dosing frequency _____

Criteria Questions:

What is the ICD-10 code: _____

1. Has the patient previously received one complete treatment course of Abecma, another chimeric antigen (CAR) T-cell therapy directed at any target (e.g., Carvykti, Yescarta), or any therapy that is targeted to B-cell maturation antigen (BCMA) (e.g., Blenrep)?

❒ Yes, *Continue to 2*
❒ No, *Continue to 2*

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2. What is the diagnosis?

❒ Multiple myeloma, *Continue to 3*

❒ Other, please specify. _____, *Continue to 3*

3. Does the patient have relapsed or refractory multiple myeloma?

❒ Yes, *Continue to 4*

❒ No, *Continue to 4*

4. Has the patient received at least four prior therapies/regimens for multiple myeloma? ***ACTION REQUIRED***: If Yes, attach supporting chart note(s).

❒ Yes, *Continue to 5*

❒ No, *Continue to 5*

5. Has the patient received at least one immunomodulatory agent (e.g., Revlimid)? ***ACTION REQUIRED***: If Yes, attach supporting chart note(s).

❒ Yes, *Continue to 6*

❒ No, *Continue to 6*

6. Has the patient received at least one proteasome inhibitor (e.g., Velcade)? ***ACTION REQUIRED***: If Yes, attach supporting chart note(s).

❒ Yes, *Continue to 7*

❒ No, *Continue to 7*

7. Has the patient received at least one anti-CD38 monoclonal antibody (e.g., Darzalex)? ***ACTION REQUIRED***: If Yes, attach supporting chart note(s).

❒ Yes, *Continue to 8*

❒ No, *Continue to 8*

8. Does the patient have an Eastern Cooperative Oncology Group (ECOG) performance status of 0 to 2 (patient is ambulatory and capable of all self-care but unable to carry out any work activities. Up and about more than 50% of waking hours)?

❒ Yes, *Continue to 9*

❒ No, *Continue to 9*

9. Does the patient have adequate and stable kidney, liver, pulmonary and cardiac function?

❒ Yes, *Continue to 10*

❒ No, *Continue to 10*

10. Does the patient have a history or presence of clinically relevant central nervous system (CNS) pathology?

❒ Yes, *Continue to 11*

❒ No, *Continue to 11*

11. Does the patient have clinically significant active infection?

❒ Yes, *Continue to 12*

❒ No, *Continue to 12*

12. Does the patient have active graft versus host disease?

❒ Yes, *Continue to 13*

❒ No, *Continue to 13*

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13. Does the patient have an active inflammatory disorder?
❒ Yes, *Continue to 14*
❒ No, *Continue to 14*

14. What is the patient's age in years?
❒ Less than 18 years of age, *No Further Questions*
❒ 18 years of age or older, *No Further Questions*

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X_____
Prescriber or Authorized Signature **Date (mm/dd/yy)**

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