Kyprolis

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 _____

Send completed form to: Priority Partners Fax: 1-866-212-4756

Criteria Questions:

1. What is the diagnosis?

❒ Multiple myeloma, *Continue to #2*

❒ Systemic light chain amyloidosis, *Continue to #2*

❒ Waldenstrom macroglobulinemia/lymphoplasmacytic lymphoma, *Continue to #2*

❒ Other, *Continue to #2*

2. Is this a request for continuation of therapy with the requested medication?

❒ Yes, *Continue to #3*

❒ No, *Continue to #4*

3. Has the patient experienced unacceptable toxicity or disease progression while on the current regimen?

❒ Yes, *Continue to #200*

❒ No, *Continue to #200*

4. What is the diagnosis?

❒ Multiple myeloma, *Continue to #5*

❒ Waldenstrom macroglobulinemia/lymphoplasmacytic lymphoma, *Continue to #100*

❒ Systemic Light Chain Amyloidosis, *Continue to #150*

5. What is the prescribed regimen?

❒ The requested medication in combination with dexamethasone, *Continue to #10*

❒ The requested medication in combination with cyclophosphamide and dexamethasone, *Continue to #200*

❒ The requested medication in combination with lenalidomide and dexamethasone, *Continue to #200*

❒ The requested medication in combination with daratumumab, lenalidomide and dexamethasone, *Continue to #200*

❒ The requested medication in combination with daratumumab and dexamethasone, *Continue to #20*

❒ The requested medication in combination with daratumumab, hyaluronidase-fihj and dexamethasone, *Continue to #25*

❒ The requested medication in combination with pomalidomide and dexamethasone, *Continue to #30*

❒ The requested medication in combination with cyclophosphamide, thalidomide, and dexamethasone, *Continue to #40*

❒ The requested medication in combination with isatuximab-irfc and dexamethasone, *Continue to #50*

❒ The requested medication in combination with selinexor and dexamethasone, *Continue to #55*

❒ The requested medication as a single agent, *Continue to #60*

❒ The requested medication in combination with lenalidomide, *Continue to #70*

❒ The requested medication in combination with bendamustine and dexamethasone, *Continue to #80*

❒ Other, *No Further Questions*

10. What is the clinical setting in which the requested medication will be used?

❒ Relapsed disease, *Continue to #200*

❒ Refractory disease, *Continue to #200*

❒ Progressive disease, *Continue to #200*

❒ Other, *Continue to #200*

20. What is the clinical setting in which the requested medication will be used?

❒ Relapsed disease, *Continue to #200*
❒ Refractory disease, *Continue to #200*
❒ Progressive disease, *Continue to #200*
❒ Other, *Continue to #200*

25. What is the clinical setting in which the requested medication will be used?

❒ Relapsed disease, *Continue to #200*
❒ Refractory disease, *Continue to #200*
❒ Progressive disease, *Continue to #200*
❒ Other, *Continue to #200*

30. What is the clinical setting in which the requested medication will be used?

❒ Relapsed disease, *Continue to #200*
❒ Progressive disease, *Continue to #200*
❒ Other, *Continue to #200*

40. What is the clinical setting in which the requested medication will be used?

❒ Relapsed disease, *Continue to #200*
❒ Progressive disease, *Continue to #200*
❒ Other, *Continue to #200*

50. What is the clinical setting in which the requested medication will be used?

❒ Relapsed disease, *Continue to #200*
❒ Progressive disease, *Continue to #200*
❒ Other, *Continue to #200*

55. What is the clinical setting in which the requested medication will be used?

❒ Relapsed disease, *Continue to #200*
❒ Progressive disease, *Continue to #200*
❒ Other, *Continue to #200*

60. Has the patient received at least one prior therapy?

❒ Yes, *Continue to #200*
❒ No, *Continue to #200*

70. Will the requested medication be used as maintenance therapy for symptomatic disease?

❒ Yes, *Continue to #200*

❒ No, *Continue to #200*

80. Has the patient received more than 3 prior therapies?

❒ Yes, *Continue to #81*

❒ No, *Continue to #81*

81. What is the clinical setting in which the requested medication will be used?

❒ Relapsed disease, *Continue to #200*
❒ Progressive disease, *Continue to #200*
❒ Other, *Continue to #200*

150. What is the clinical setting in which the requested medication will be used?

❒ Relapsed disease, *Continue to #200*
❒ Refractory disease, *Continue to #200*
❒ Other, *Continue to #200*

200. What is the patient's height in inches? _____ (Fill-in-the blank)

Continue to #201

201. What is the patient's weight in pounds? _____ (Fill-in-the-blank)

Continue to #202

202. What is the patient's Body Surface Area (BSA)? (Note: average adult BSA is around 1.7 m2) _____ (Fill-in-the-blank)

Continue to #203

203. What is the patient's dose in milligrams? _____ (Fill-in-the-blank)

Continue to #204

204. How frequently will the patient be receiving the requested medication?

❒ Once weekly, *Continue to #205*
❒ Twice weekly, *Continue to #207*

205. Will the patient's dose exceed 70 mg/m2 (not to exceed 154 mg per dose)?

❒ Yes, *Continue to #206*
❒ No, *Continue to #206*

206. Will the patient be receiving more than 3 doses per 28 days?

❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

207. Will the patient's dose exceed 56 mg/m2 (not to exceed 124 mg per dose)?

❒ Yes, *Continue to #208*
❒ No, *Continue to #208*

208. Will the patient be receiving more than 6 doses per 28 days?

❒ Yes, *No Further Questions*
❒ No, *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 Priority Partners.

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

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