Abecma

CareFirst Prior Authorization Request

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-855-330-1720**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-888-877-0518.** For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

The recipient of this fax may make a request to opt-out of receiving telemarketing fax transmissions from CVS Caremark. There are numerous ways you may opt-out: The recipient may call the toll-free number at 877-265-2711, at any time, 24 hours a day/7 days a week. The recipient may also send an opt-out request via email to do_not_call@cvscaremark.com. An opt out request is only valid if it (1) identifies the number to which the request relates, and (2) if the person/entity making the request does not, subsequent to the request, provide express invitation or permission to CVS Caremark to send facsimile advertisements to such person/entity at that particular number. CVS Caremark is required by law to honor an opt-out request within thirty days of receipt.

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*	❑ *Pharmacy*

What is the ICD-10 code? _____

Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-855-330-1720

Criteria Questions:

1. Has the patient previously received one complete treatment course of Abecma or another chimeric antigen (CAR) T-cell therapy directed at any target (e.g., Carvykti, Yescarta)?
Check the patient's PA history to ensure the patient has not had one previous course of Abecma or another CAR T-cell therapy.
❒ Yes, *Continue to 2*
❒ No, *Continue to 2*

2. What is the diagnosis?
❒ Multiple myeloma, *Continue to 3*
❒ Other, please specify. _____, *Continue to 3*

3. What is the clinical setting in which the requested drug will be used?
❒ Relapsed disease, *Continue to 4*
❒ Refractory disease, *Continue to 4*
❒ Other, please specify. _____, *Continue to 4*

4. Has the patient received at least two prior lines of therapy for multiple myeloma, including at least one drug from each of the following categories: A) anti-CD38 monoclonal antibody (e.g., daratumumab), B) proteasome inhibitor (e.g., bortezomib, ixazomib, carfilzomib), and C) immunomodulatory agent (e.g., lenalidomide, pomalidomide)? ***ACTION REQUIRED***: If Yes, attach supporting chart note(s).
❒ Yes, *Continue to 5*
❒ No, *Continue to 5*

5. 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 6*
❒ No, *Continue to 6*

6. Does the patient have adequate and stable kidney, liver, pulmonary and cardiac function?
❒ Yes, *Continue to 7*
❒ No, *Continue to 7*

7. Does the patient have a history or presence of clinically relevant central nervous system (CNS) pathology such as epilepsy, seizure, paresis, aphasia, stroke, subarachnoid hemorrhage or other CNS bleed, severe brain injuries, dementia, Parkinson's disease, cerebellar disease, organic brain syndrome, or psychosis?
❒ Yes, *Continue to 8*
❒ No, *Continue to 8*

8. Does the patient have clinically significant active infection?
❒ Yes, *Continue to 9*
❒ No, *Continue to 9*

9. Does the patient have active graft versus host disease?
❒ Yes, *Continue to 10*
❒ No, *Continue to 10*

10. Does the patient have an active inflammatory disorder?
❒ Yes, *No Further Questions*
❒ No, *Continue to 11*

11. What is the patient's age in years?
_____ years of age, *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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