Kyprolis

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

 Kyprolis SGM 2370-C – 04/2025.

CVS Caremark Specialty Pharmacy ● 2211 Sanders Road NBT-6 ● Northbrook, IL 60062
Phone: 1-888-877-0518 ● Fax: 1-855-330-1720 ● www.caremark.com

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*

❒ POEMS (polyneuropathy, organomegaly, endocrinopathy, monoclonal protein, skin changes) syndrome, *Continue to 2*

❒ Other, please specify. _____, *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 22*

❒ No, *Continue to 22*

4. What is the diagnosis?

❒ Multiple myeloma, *Continue to 5*

❒ Systemic light chain amyloidosis, *Continue to 22*

❒ Waldenstrom macroglobulinemia/lymphoplasmacytic lymphoma, *Continue to 22*

❒ POEMS (polyneuropathy, organomegaly, endocrinopathy, monoclonal protein, skin changes) syndrome, *Continue to 21*

5. What is the prescribed regimen?

❒ The requested medication in combination with dexamethasone, *Continue to 6*

❒ The requested medication in combination with cyclophosphamide and dexamethasone, *Continue to 22*

❒ The requested medication in combination with lenalidomide and dexamethasone, *Continue to 22*

❒ The requested medication in combination with daratumumab, lenalidomide and dexamethasone, *Continue to 22*

❒ The requested medication in combination with daratumumab and dexamethasone, *Continue to 7*

❒ The requested medication in combination with daratumumab, hyaluronidase-fihj and dexamethasone, *Continue to 8*

❒ The requested medication in combination with pomalidomide and dexamethasone, *Continue to 9*

❒ The requested medication in combination with pomalidomide, daratumumab, and dexamethasone, *Continue to 9*

❒ The requested medication in combination with cyclophosphamide, thalidomide, and dexamethasone, *Continue to 10*

❒ The requested medication in combination with isatuximab-irfc and dexamethasone, *Continue to 11*

❒ The requested medication in combination with selinexor and dexamethasone, *Continue to 12*

❒ The requested medication as a single agent, *Continue to 13*

❒ The requested medication in combination with lenalidomide, *Continue to 14*

❒ The requested medication in combination with bendamustine and dexamethasone, *Continue to 15*

❒ The requested medication in combination with venetoclax and dexamethasone, *Continue to 17*

❒ The requested medication in combination with isatuximab-irfc, lenalidomde, and dexamethasone, *Continue to 19*

❒ Other, please specify. _____, *Continue to 22*

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

❒ Relapsed disease, *Continue to 22*

❒ Refractory disease, *Continue to 22*

❒ Progressive disease, *Continue to 22*

❒ Other, please specify. _____, *Continue to 22*

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

❒ Relapsed disease, *Continue to 22*

❒ Refractory disease, *Continue to 22*

❒ Progressive disease, *Continue to 22*

❒ Other, please specify. _____, *Continue to 22*

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

❒ Relapsed disease, *Continue to 22*

❒ Refractory disease, *Continue to 22*

❒ Progressive disease, *Continue to 22*

❒ Other, please specify. _____, *Continue to 22*

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

❒ Relapsed disease, *Continue to 22*

❒ Progressive disease, *Continue to 22*

❒ Other, please specify. _____, *Continue to 22*

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

❒ Relapsed disease, *Continue to 22*

❒ Progressive disease, *Continue to 22*

❒ Other, please specify. _____, *Continue to 22*

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

❒ Relapsed disease, *Continue to 22*

❒ Refractory disease, *Continue to 22*

❒ Progressive disease, *Continue to 22*

❒ Other, please specify. _____, *Continue to 22*

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

❒ Relapsed disease, *Continue to 22*

❒ Progressive disease, *Continue to 22*

❒ Other, please specify. _____, *Continue to 22*

13. Has the patient received at least one prior therapy?
❒ Yes, *Continue to 22*
❒ No, *Continue to 22*

14. Will the requested medication be used as maintenance therapy for symptomatic disease?
❒ Yes, *Continue to 22*
❒ No, *Continue to 22*

15. Has the patient received more than 3 prior therapies?
❒ Yes, *Continue to 16*
❒ No, *Continue to 16*

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

❒ Relapsed disease, *Continue to 22*

❒ Refractory disease, *Continue to 22*

❒ Other, please specify. _____, *Continue to 22*

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

❒ Relapsed disease, *Continue to 18*

❒ Progressive disease, *Continue to 18*

❒ Other, please specify. _____, *Continue to 18*

18. Does the patient have a documented t(11:14) translocation? ***ACTION REQUIRED***: If Yes, attach chart note(s) or test results of t(11:14) translocation.

❒ Yes ***ACTION REQUIRED****: Submit supporting documentation, Continue to 22*

❒ No, *Continue to 22*

❒ Unknown, *Continue to 22*

19. Will the requested medication be used as primary therapy for symptomatic disease?
❒ Yes, *Continue to 20*
❒ No, *Continue to 20*

20. Is the patient a candidate for transplant?
❒ Yes, *Continue to 22*
❒ No, *Continue to 22*

21. Will the requested medication be used in combination with dexamethasone?
❒ Yes, *Continue to 22*
❒ No, *Continue to 22*

22. What is the patient's height in inches? _____ inches, *Continue to 23*

23. What is the patient's weight in pounds? _____ pounds, *Continue to 24*

24. What is the patient's Body Surface Area (BSA) (Note: average adult BSA is around 1.7 m2)? _____m2, *Continue to 25*

25. What is the patient's dose in milligrams? _____ mg, *Continue to 26*

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

❒ Once weekly, *Continue to 27*

❒ Twice weekly, *Continue to 29*

27. Will the patient's dose exceed 70 mg/m2 (not to exceed 154 mg per dose)?
❒ Yes, *Continue to 28*
❒ No, *Continue to 28*

28. Will the patient be receiving more than 3 doses per 28 days?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

29. Will the patient's dose exceed 56 mg/m2 (not to exceed 124 mg per dose)?
❒ Yes, *Continue to 30*
❒ No, *Continue to 30*

30. 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 CVS Caremark or the benefit plan sponsor.

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

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