BlueCross BlueShield
Federal Employee Program

# KYPROLIS
# PRIOR APPROVAL REQUEST

**Send completed form to:**
**Service Benefit Plan**
**Prior Approval**
**P.O. Box 52080 MC 139**
**Phoenix, AZ 85072-2080**
**Attn. Clinical Services**
**Fax: 1-877-378-4727**

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

| **Patient Information (required)** | | | **Provider Information (required)** | | |
|---|---|---|---|---|---|
| Date: | | | Provider Name: | | |
| Patient Name: | | | Specialty: | NPI: | |
| Date of Birth: | Sex: ❑Male ❑Female | | Office Phone: | Office Fax: | |
| Street Address: | | | Office Street Address: | | |
| City: | State: | Zip: | City: | State: | Zip: |
| Patient ID: **R** | | | Physician Signature: | | |
| **PHYSICIAN COMPLETES** | | | | | |

## Kyprolis (carfilzomib)

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

**NOTE**: Form must be completed in its **entirety** for processing

Is this request for brand or generic? ❑Brand ❑Generic

1. What is the patient's diagnosis?

❑Relapsed or refractory Multiple Myeloma (MM)

a. Has the patient been on Kyprolis continuously for the last **6 months**, excluding samples? ***Please select answer below:***

❑**NO** – this is **INITIATION** of therapy, please answer the following questions:

i. Is the patient taking Kyprolis as a single agent or in combination with another medication(s)? ***Select answer below:***

❑**Single agent**: Has the patient received one or more lines of multiple myeloma therapy? ❑Yes ❑No

❑**In combination with another medication(s)**: Please answer the following questions:

1) Will Kyprolis be used in combination with one of the following? ***Please select one of the following below***:

| | | |
|---|---|---|
| ❑No | ❑Dexamethasone/daratumumab (Darzalex) | ❑Dexamethasone/lenalidomide (Revlimid) |
| ❑Dexamethasone | ❑Dexamethasone/isatuximab-irfc (Sarclisa) | ❑Dexamethasone/daratumumab/hyaluronidase-fihj (Darzalex Faspro) |

2) Has the patient received one to three lines of multiple myeloma therapy? ❑Yes ❑No

❑**YES** - this is a PA renewal for **CONTINUATION** of therapy, please answer the following questions:

i. Is the patient taking Kyprolis as a single agent or in combination with another medication(s)? ***Select answer below:***

❑**Single agent**

❑**In combination with another medication(s)**: Will Kyprolis be used in combination with one of the following:

| | | |
|---|---|---|
| ❑No | ❑Dexamethasone/daratumumab (Darzalex) | ❑Dexamethasone/lenalidomide (Revlimid) |
| ❑Dexamethasone | ❑Dexamethasone/isatuximab-irfc (Sarclisa) | ❑Dexamethasone/daratumumab/hyaluronidase-fihj (Darzalex Faspro) |

ii. Has the patient experienced disease progression or unacceptable toxicity while on Kyprolis? ❑Yes ❑No

❑Waldenstrom's macroglobulinemia / lymphoplasmacytic lymphoma

a. Will Kyprolis be used in combination with rituximab (Rituxan) and dexamethasone? ❑Yes ❑No

b. Has the patient been on Kyprolis continuously for the last **6 months**, excluding samples? ❑Yes***** ❑No

****If YES***, has the patient experienced disease progression or unacceptable toxicity while on Kyprolis? ❑Yes ❑No

❑Other diagnosis ***(please specify)***: _____

2. **FEMALE Patient**: Is the patient of reproductive potential? ❑Yes***** ❑No

****If YES***, will the patient be advised to use effective contraception during treatment with Kyprolis and for six months after the final dose? ❑Yes ❑No

**MALE Patient**: Does the patient have a female partner of reproductive potential? ❑Yes***** ❑No

****If YES***, will the patient be advised to use effective contraception during treatment with Kyprolis and for three months after the final dose? ❑Yes ❑No

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Message:

Attached is a Prior Authorization request form.

For your convenience, there are 3 ways to complete a Prior Authorization request:

| | |
|---|---|
| **Electronically Online** (ePA) Results in 2-3 **minutes** **FASTEST AND EASIEST** | Now you can get responses to drug Prior Authorization requests **securely** online. **Online** submissions may receive **instant** responses and do not require faxing or phone calls. Requests can be made 24 hours a day, 7 days a week. For more information on electronic prior authorization (ePA) and to register, go to **Caremark.com/ePA.** |
| **Phone** (4-5 **minutes** for response) | The FEP Clinical Call Center can be reached at **(877)-727-3784** between the hours of 7AM-9PM Eastern Time. A live representative will assist with the Prior Authorization, asking for the same information contained on the attached form. Please review the form and have your answers ready for faster service. The process over the phone takes on average between 4 and 5 minutes. |
| **Fax** (3-5 **days** for response) | Fax the attached form to **(877)-378-4727**. Requests sent via fax will be processed and responded to within 5 business days. The form must be filled out completely, if there is any missing information the Prior Authorization request cannot be processed. ***Please only fax the completed form once as duplicate submissions may delay processing times.*** |