BlueCross BlueShield Federal Employee Program

SARCLISA
PRIOR APPROVAL REQUEST

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.

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

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					

Sarclisa (isatuximab-irfc)

****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. Does the patient have a diagnosis of multiple myeloma (MM)? ❑Yes* ❑No

   If YES, has the patient been on Sarclisa continuously for the last **6 months**, excluding samples? ***Please select answer below:***

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

   a. Is the multiple myeloma newly diagnosed? ***Please select answer below:***

   ❑**Yes**: Please answer the following questions:

   i. Is the patient eligible for autologous stem cell transplant (ASCT)? ❑Yes ❑No

   ii. Will this medication be used in combination with bortezomib (Velcade)*, lenalidomide (Revlimid)*, and dexamethasone? ***Velcade (bortezomib) and Revlimid (lenalidomide) require prior-authorization.***

   ❑**No**: Will Sarclisa be used in combination with ether pomalidomide (Pomalyst) and dexamethasone or carfilzomib (Kyprolis) and dexamethasone? ❑Yes* ❑No

   If YES, please select one of the following and answer the following question(s):

   ❑**Carfilzomib (Kyprolis)* and dexamethasone**: Please answer the following questions:
   Kyprolis (carfilzomib) requires prior-authorization.

   i. Does the patient have relapsed or refractory multiple myeloma (RRMM)? ❑Yes ❑No

   ii. Has the patient received one to three prior lines of therapy? ❑Yes ❑No

   ❑**Pomalidomide (Pomalyst)* and dexamethasone**: Has the patient received at least two prior therapies including a proteasome inhibitor (PI) and lenalidomide (Revlimid)? ❑Yes ❑No
   Pomalyst (pomalidomide) requires prior-authorization

   ❑**YES** – this is a PA renewal for **CONTINUATION** therapy, please answer the following question:

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

2. Does the prescriber agree to monitor complete blood counts (CBC)? ❑Yes ❑No

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

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