



Chemotherapy: Multiple Myeloma Drugs
Zolgensma (onasemnogene) J3399, Darzalex (daratumumab)
J9145, Empliciti (elotuzumab) J9176, Kyprolis (carfilzomib)
J9047, Abecma (idecabtagene vicieucel) Q2055
Prior Authorization Request
Medicare Part B Form

*Instructions: * Indicates required information – Form may be returned if required information is not provided. Please fax this request to the appropriate fax number listed at the bottom of the page.*

<input type="checkbox"/>	NEW START - Start Date: _____	<input type="checkbox"/>	Continuation (within 365 days): Date of last treatment _____
<input type="checkbox"/>	Date Requested _____		
	Requestor _____	Clinic name: _____	Phone _____ / Fax _____

MEMBER INFORMATION

*Name: _____ *ID#: _____ *DOB: _____

PRESCRIBER INFORMATION

*Name: _____ MD FNP DO NP PA *Phone: _____

*Address: _____ *Fax: _____

DISPENSING PROVIDER / ADMINISTRATION INFORMATION

*Name: _____ Phone: _____

*Address: _____ Fax: _____

PROCEDURE / PRODUCT INFORMATION

HCPC Code	Name of Drug <input type="checkbox"/> Self-administered	Dose (Wt: _____ kg Ht: _____)	Frequency	End Date if known

Chart notes attached. **Other important information:** _____

Diagnosis: ICD10: _____ **Description:** _____

Provider attests the diagnosis provided is an FDA-Approved indication for this drug

CLINICAL INFORMATION

New Start or Initial Request: (Clinical documentation required for all requests)
 Provider has reviewed the attached “Criteria for Approval” and attests the member meets ALL required PA criteria.
 If not, please provide **clinical rationale** for formulary exception: _____

Continuation Requests: (Clinical documentation required for all requests)
 Provider has reviewed the attached “Criteria for Continuation” and attests the member meets ALL required PA Continuation criteria.
 Patient had an adequate response or significant improvement while on this medication.
 If not, please provide clinical rationale for continuing this medication: _____

ACKNOWLEDGEMENT

Request By (Signature Required): _____ **Date:** ____ / ____ / ____

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. **THIS AUTHORIZATION IS NOT A GUARANTEE OF PAYMENT. PAYMENT IS BASED ON BENEFITS IN EFFECT AT THE TIME OF SERVICE, MEMBER ELIGIBILITY AND MEDICAL NECESSITY.**

For questions or assistance, please contact Customer Service at 1-877-672-8620, daily, 8am – 8pm (PST) (TTY users should call 1-800-735-2900).

Prior Authorization Group – Oncology: Multiple Myeloma PA

Drug Name(s):

DARZALEX
EMPLICITI
KYPROLIS

ZOLGENSMA
ABECMA

Criteria for approval of Prior Authorization Drug:

1. Prescribed for an approved FDA diagnosis (as listed below):
2. Prescribed by, or in consultation with an oncologist or other cancer specialist related to the diagnosis.
3. Drug is being used appropriately per CMS recognized compendia, authoritative medical literature, evidence-based guidelines and/or accepted standards of medical practice.
4. Member does not have any clinically relevant contraindications, or CMS/Plan exclusions, to the requested drug.
 - If the member meets all these criteria, they may be approved by the Plan for the requested drug.
 - Quantity limits and Tiering will be determined by the Plan.

Exclusion Criteria:

Cannot be prescribed for experimental or investigational use.

Prescriber Restrictions:

Oncologist or other cancer specialist

Coverage Duration:

New Start: Approval will be for 6 months

Continuation: Approval will be for 12 months

Zolgensma: To be individually determined

FDA Indications:

Darzalex

- Multiple myeloma, In combination with pomalidomide plus dexamethasone in patients who have received at least two prior therapies including lenalidomide and a proteasome inhibitor
- Multiple myeloma, Relapsed or refractory, in combination with lenalidomide and dexamethasone in patients who have received at least one prior therapy
- Multiple myeloma, Monotherapy, in patients who have received at least 3 prior therapies including a proteasome inhibitor and an immunomodulatory agent or are double-refractory to a proteasome inhibitor and an immunomodulatory agent
- Multiple myeloma, In combination with bortezomib, melphalan, and predniSONE in newly diagnosed patients who are ineligible for autologous stem cell transplant
- Multiple myeloma, In combination with bortezomib, thalidomide, and dexamethasone in newly diagnosed patients who are eligible for autologous stem cell transplant
- Multiple myeloma, In combination with bortezomib plus dexamethasone in patients who have received at least one prior therapy
- Multiple myeloma, Newly-diagnosed, in combination with lenalidomide and dexamethasone in patients who are ineligible for autologous stem cell transplant
- Multiple myeloma, Relapsed or refractory, in combination with carfilzomib plus dexamethasone, after 1 to 3 prior therapies

Empliciti

- Multiple myeloma, In combination with lenalidomide and dexamethasone following treatment with 1 to 3 prior therapies
- Multiple myeloma, In combination with pomalidomide and dexamethasone following treatment with at least 2 prior therapies including lenalidomide and a proteasome inhibitor

Kyprolis

- Multiple myeloma, Relapsed or refractory, in combination with daratumumab plus dexamethasone, after 1 to 3 prior therapies
- Multiple myeloma, Relapsed or refractory, in combination with daratumumab plus dexamethasone or daratumumab/hyaluronidase-fihj plus dexamethasone, after 1 to 3 prior therapies
- Multiple myeloma, Relapsed or refractory, in combination with isatuximab plus dexamethasone, after 1 to 3 prior therapies
- Multiple myeloma, Relapsed or refractory, monotherapy, after at least 1 prior therapy

Abecma

- Multiple myeloma, Relapsed or refractory, after 4 or more prior lines of therapy

Zolgensma

- Spinal muscular atrophy, Bi-allelic survival motor neuron 1 (SMN1) gene mutations

Off-Label Uses:

Darzalex

- AL amyloidosis, Relapsed or refractory

Empliciti

N/A

Kyprolis

- Multiple myeloma, Newly diagnosed, transplant-eligible, in combination with an immunomodulatory drug and steroid
- Multiple myeloma, Newly diagnosed, transplant-ineligible, in combination with a chemotherapy agent and a steroid
- Waldenstrom macroglobulinemia

Age Restrictions:

Safety and effectiveness not established in pediatric patients

Other Clinical Considerations:

Cancer diagnoses: Criteria as per NCCN or other FDA-approved cancer related guidelines.

Resources:

https://www.micromedexsolutions.com/micromedex2/librarian/CS/015132/ND_PR/evidencexpert/ND_P/evidencexpert/DUPLICATIONSHIELDSYNC/B7B02D/ND_PG/evidencexpert/ND_B/evidencexpert/ND_AppProduct/evidencexpert/ND_T/evidencexpert/PFActionId/evidencexpert.GoToDashboard?docId=931659&contentSetId=100&title=Daratumumab&servicesTitle=Daratumumab&brandName=Darzalex&UserMdxSearchTerm=Darzalex&=null#

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Part B Prior Authorization Guidelines

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CLINICAL / CMS
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