

Epkinly® (epcoritamab-bysp) Prior Authorization Form

Member Name: _____ Date of Birth: _____ Member ID#: _____

Drug Information

Physician billing (HCPCS code: _____) Start Date (or date of next dose): _____

Dose: _____ Regimen: _____

Billing Provider Information

Provider NPI: _____ Provider Name: _____

Provider Phone: _____ Provider Fax: _____

Prescriber Information

Prescriber NPI: _____ Prescriber Name: _____

Prescriber Phone: _____ Prescriber Fax: _____ Specialty: _____

Criteria**For Initial Authorization:**

1. Please indicate the diagnosis and information:

 Diffuse Large B-Cell Lymphoma (DLBCL)

A. Is diagnosis relapsed or refractory DLBCL not otherwise specified, including DLBCL arising from indolent lymphomas and/or high-grade B-cell lymphomas? Yes ___ No ___

B. Has the member received 2 or more lines of systemic therapy? Yes ___ No ___

 Follicular Lymphoma (FL)

A. Is diagnosis relapsed or refractory FL? Yes ___ No ___

B. Has the member received 2 or more lines of systemic therapy? Yes ___ No ___

i. If yes, will Epkinly® be used as a single agent? Yes ___ No ___

C. Has the member received 1 or more lines of systemic therapy? Yes ___ No ___

i. If yes, will Epkinly® be used in combination with lenalidomide and rituximab? Yes ___ No ___

 Other: _____**For Continued Authorization:**

1. Date of last dose: _____

2. Does member have any evidence of progressive disease while on Epkinly® therapy? Yes ___ No ___

3. Has member experienced any adverse drug reactions related to Epkinly® therapy? Yes ___ No ___

If yes, please specify adverse reactions: _____

Additional Information: _____

Prescriber Signature: _____ Date: _____

I certify that the indicated treatment is medically necessary and all information is true and correct to the best of my knowledge. Failure to complete this form in full will result in processing delays.

PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:

University of Oklahoma College of Pharmacy
Pharmacy Management Consultants
Product Based Prior Authorization UnitFax: 1-800-224-4014
Phone: 1-800-522-0114 Option 4CONFIDENTIALITY NOTICE

This document, including any attachments, contains information which is confidential or privileged. If you are not the intended recipient, be aware that any disclosure, copying, distribution, or use of the contents of this information is prohibited. If you have received this document in error, please notify the sender immediately by telephone to arrange for the return of the transmitted documents or to verify their destruction.