

**Sarclisa® (isatuximab-irfc) Prior Authorization Form**

**Member Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_ **Member ID#:** \_\_\_\_\_

**Drug Information**

**Physician billing** (HCPCS code: \_\_\_\_\_)  **Pharmacy billing** (NDC: \_\_\_\_\_)

**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 provide the diagnosis and information:

**Multiple Myeloma**

- A. Will isatuximab be used as primary therapy? Yes \_\_\_ No \_\_\_
- B. Will isatuximab be used in combination with bortezomib, lenalidomide, and dexamethasone? Yes \_\_\_ No \_\_\_
- C. Will isatuximab be used in combination with carfilzomib, lenalidomide, and dexamethasone? Yes \_\_\_ No \_\_\_
  - i. If yes, is member transplant eligible? Yes \_\_\_ No \_\_\_
- D. Will isatuximab be used in combination with lenalidomide and dexamethasone? Yes \_\_\_ No \_\_\_
  - i. If yes, is transplant deferred or not indicated? Yes \_\_\_ No \_\_\_

**Relapsed or Refractory Multiple Myeloma (RRMM)**

- A. Will isatuximab be used in combination with pomalidomide and dexamethasone? Yes \_\_\_ No \_\_\_
  - i. If yes, has the member failed at least 2 prior therapies? Yes \_\_\_ No \_\_\_
    - a. If yes, did the prior therapies include lenalidomide and a proteasome inhibitor? Yes \_\_\_ No \_\_\_
- B. Will isatuximab be used in combination with carfilzomib and dexamethasone? Yes \_\_\_ No \_\_\_
  - i. If yes, has the member failed 1 to 3 prior therapies? Yes \_\_\_ No \_\_\_

**Other:** \_\_\_\_\_

**Additional Information:** \_\_\_\_\_

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PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:

University of Oklahoma College of Pharmacy  
Pharmacy Management Consultants  
Product Based Prior Authorization Unit

Fax: 1-800-224-4014  
Phone: 1-800-522-0114 Option 4

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State of Oklahoma  
SoonerCare

Sarclisa® (isatuximab-irfc) Prior Authorization Form

Member Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Member ID#: \_\_\_\_\_

Criteria

For Continued Authorization:

- 1. Date of last dose: \_\_\_\_\_
  - 2. Does member have any evidence of progressive disease while isatuximab therapy? Yes \_\_\_ No \_\_\_
  - 3. Has member experienced any adverse drug reactions related to isatuximab 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. Please do not send in chart notes. Specific information will be requested if necessary. Failure to complete this form in full will result in processing delays.*

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