State of Oklahoma
SoonerCare
Abecma® (idecabtagene vicleucel) Prior Authorization Form

Member Name:**____________________** ***Date of Birth:*****______________** ***Member ID#:*****________________**

Drug Information

Physician billing (HCPCS code:_______________) ***Start Date:_______________________________***

Billing Provider Information

Provider NPI:________________________________ ***Provider Name:_____________________________***

Provider Phone:____________________________ ***Provider Fax:______________________________***

Prescriber Information

Prescriber NPI:_____________________ ***Prescriber Name:______________________________________***

Prescriber Phone:_______________ ***Prescriber Fax:________________*** ***Specialty:__________________***

Criteria

For Authorization:

1. Please include the most recent office visit note or clinical summary from the hospital to support your request. Is this information attached? Yes____ No____
2. Is the health care facility a qualified treatment center to administer chimeric antigen receptor (CAR) T-cells? Yes____ No____
3. Is the health care facility trained in the management of cytokine release syndrome (CRS) and neurologic toxicities? Yes____ No____
4. Please indicate the diagnosis and information:

❑ **Multiple Myeloma**

A. Is disease status relapsed or refractory? Yes____ No____

B. Has member received at least 2 prior lines of therapy including an immunomodulatory agent, a proteasome inhibitor, and an anti-CD38 monoclonal antibody? Yes____ No____

C. Please list therapies member has tried and failed:

____

i. For the therapies listed, did the member undergo at least 2 consecutive cycles of treatment for each regimen? Yes____ No____

1. If no, please list therapies member received for less than 2 consecutive cycles:

____

a. Was progressive disease seen after 1 cycle of each of these therapies? Yes____ No____

ii. Do the therapies listed include I nduction with or without autologous hematopoietic stem cell transplant with or without maintenance therapy? Yes____ No____

D. Does the member have measurable disease as evidenced by at least 1 of the following? Yes____ No____ Please check all that apply:

____Urine M-protein ≥200mg/24hr ____Bone marrow plasma cells >30% of total bone marrow cells

____Serum M-protein ≥0.5g/dL ____Serum free light chain (FLC) assay: involved FLC ≥10mg/dL (100mg/L)

E. Does the member have central nervous system involvement with multiple myeloma? Yes____ No____

❑ **If answer is none of the above, please indicate diagnosis**:____________________________________

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 PROVIDE THE INFORMATION REQUESTED AND RETURN TO:	CONFIDENTIALITY NOTICE
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	*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.*