

Lynozytic™ (linvoseltamab-gcpt) 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:

Multiple Myeloma

- A. Is diagnosis relapsed or refractory multiple myeloma? Yes ___ No ___
- B. Has member received at least 4 prior lines of therapy, including a proteasome inhibitor, an immunomodulatory agent, and an anti-CD38 monoclonal antibody? Yes ___ No ___
- C. Is health care facility trained in the management of cytokine release syndrome (CRS) and neurologic toxicities? Yes ___ No ___
- D. Will health care facility comply with the risk evaluation and mitigation strategy (REMS) requirements? Yes ___ No ___

If diagnosis is not listed above, please indicate diagnosis: _____

For Continued Authorization:

1. Date of last dose: _____

2. Does the member have any evidence of progressive disease while on Lynozytic™? Yes ___ No ___

3. Has the member experienced any adverse drug reactions related to Lynozytic™ 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 Unit

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

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