

## Talvey® (talquetamab-tgvs) Prior Authorization Form

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

### Drug Information

**Physician billing (HCPCS code:** \_\_\_\_\_ **) Start Date:** \_\_\_\_\_

**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 disease relapsed or refractory? Yes \_\_\_ No \_\_\_

B. Will Talvey® be used as a single-agent? Yes \_\_\_ No \_\_\_

i. If yes, 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. Will Talvey® be used in combination with teclistamab-cgyv? Yes \_\_\_ No \_\_\_

i. If yes, has member received at least 3 prior lines of therapy? Yes \_\_\_ No \_\_\_

D. Is health care facility trained in the management of cytokine release syndrome (CRS), neurologic toxicities, and will comply with the risk evaluation and mitigation strategy (REMS) requirements?

Yes \_\_\_ No \_\_\_

**If diagnosis is not listed above, please indicate diagnosis:** \_\_\_\_\_

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

**For Continued Authorization:**

1. Date of last dose: \_\_\_\_\_

2. Does member have any evidence of progressive disease while on Talvey® therapy? Yes \_\_\_ No \_\_\_

3. Has member experienced any adverse drug reactions related to Talvey® therapy? Yes \_\_\_ No \_\_\_

*If yes, please specify adverse reactions:* \_\_\_\_\_

**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

CONFIDENTIALITY 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.*