

Tecvayli® (teclistamab-cqyv) 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 status relapsed or refractory? Yes ___ No ___
- B. Will Tecvayli® be used in combination with daratumumab? Yes ___ No ___
 - i. If yes, has member received at least 1 prior line of therapy including a proteasome inhibitor and an immunomodulatory agent? Yes ___ No ___
- C. Will Tecvayli® 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 antibody? Yes ___ No ___
- D. Will Tecvayli® be used in combination with talquetamab-tgvs? Yes ___ No ___
 - i. If yes, has member received at least 3 prior lines of therapy? Yes ___ No ___
- E. Is the health care facility trained in the management of cytokine release syndrome (CRS), neurological toxicities, and will comply with the risk evaluation and mitigation strategy (REMS) requirements?
Yes ___ No ___

Other _____

Additional information: _____

For Continued Authorization:

- 1. Date of last dose: _____
- 2. Does member have any evidence of progressive disease while on Tecvayli®? Yes ___ No ___
- 3. Has the member experienced adverse drug reactions related to Tecvayli®? 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 do not send in chart notes. Specific information will be requested if necessary.

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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