OKLAHOMA Health Care Authority

State of Oklahoma
SoonerCare
Sarclisa®/Sarclisa Escena™ (isatuximab-irfc) Prior Authorization Form

Member Name:_____ ***Date of Birth:***_____ ***Member ID#:***_____

Drug Information

Physician Billing **(HCPCS code:**_____**)** ***Start Date (or date of next dose):***_____

Medication Name: _____ ***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: _____

_____

_____

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.*

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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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