OKLAHOMA Health Care Authority

State of Oklahoma
SoonerCare
Carvykti® (ciltacabtagene autoleucel) 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 ≥1 line of prior therapy including an immunomodulatory agent and a proteasome inhibitor? Yes☐ No☐
     - C. Is member refractory to lenalidomide? Yes☐ No☐
     - D. 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☐

(continued on next page)

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

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DRAFT

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Criteria

For Authorization: *(continued)*

E. Does the member have measurable disease as evidenced by at least 1 of the following?
Yes☐ No☐ *(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)
☐ Other indicator of measurable disease submitted for case-by-case review: _____
_____
_____

F. Does the member have central nervous system involvement with multiple myeloma?
Yes☐ No☐

☐ **If answer is none of the above, please indicate diagnosis:** _____

Additional Information: _____
_____
_____
_____
_____
_____

DRAFT

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 and attach requested clinical notes will result in processing delays.

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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.*