HEALTHY U MEDICAID

PRIOR AUTHORIZATION REQUEST FORM
CARVYKTI™

For authorization, please answer each question and fax this form PLUS chart notes back to the Healthy U Prior Authorization Department at 801-213-1547.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have medical pharmacy prior authorization questions, please call for assistance: 833-981-0212

Disclaimer: Prior authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Product being requested: ☐ Carvykti™ (ciltacabtagene autoleucel)

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section.

Questions	Yes	No	Comments/Notes
RELAPSED OR REFRACTORY MULTIPLE MYELOMA			
1. Is the request made by an oncologist?	☐	☐	**Please provide documentation**
2. Is the member 18 years of age or older?	☐	☐	**Please provide documentation**
3. Does the member have a diagnosis of multiple myeloma with measurable disease including at least one of the following: • Serum monoclonal paraprotein (M-protein) ≥ 1 g/dL • Urine M-protein ≥ 200 mg/24 hours • Serum immunoglobulin free light chain (FLC) assay ≥ 10 mg/dL and abnormal serum immunoglobulin kappa lambda free light chain ratio	☐	☐	**Please provide documentation**
4. Does the member have relapsed or refractory disease, defined as progression after ≥ 4 lines of systemic therapy and includes all of the following: • Proteasome inhibitor (e.g., ixazomib, bortezomib, or carfilzomib) • Anti-CD38 antibody (e.g., isatuximab or daratumumab) • Immunomodulatory agent (e.g., thalidomide, pomalidomide, lenalidomide)	☐	☐	**Please provide documentation**
5. Does the member have an Eastern Cooperative Oncology Group (ECOG) grade of 0 or 1?	☐	☐	**Please provide documentation**

6. Does the member have adequate hematology markers defined by all of the following: • Platelet count ≥ 50,000 cells/uL • Absolute Neutrophil Count ≥ 750 cells/uL • Hemoglobin ≥ 8.0 g/dL			
7. Does the member have any of the following: • Hepatic transaminases > 3 times the upper limit of normal • Creatinine clearance < 40 mL/min • Left Ventricular Ejection Fraction (LVEF) < 45% • Active systemic viral, bacterial, or uncontrolled fungal infection. Note: Documentation must show absence of active Hepatitis B, Hepatitis C, and Human Immunodeficiency Virus (HIV) • History of chimeric antigen receptor therapy (CAR-T) or other genetically modified T-cell therapy • An allogenic stem cell transplant within 6 months before apheresis. Note: Participants who received an allogeneic transplant must be off all immunosuppressive medications for 6 weeks without signs of graft-versus-host disease (GVHD) • An autologous stem cell transplant ≤ 12 weeks before apheresis • Presence or history of central nervous system involvement with myeloma	☐	☐	**Please provide documentation**
8. Are the member and requesting provider enrolled in the Carvykti™ Risk Evaluation and Mitigation Strategy (REMS) program?	☐	☐	**Please provide documentation**
What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.			
Additional information:			
Physician Signature:			

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Policy: PHARM-HU-M039
Origination Date: 03/09/2022
Reviewed/Revised Date: 04/19/2023
Next Review Date: 04/19/2024
Current Effective Date: 05/01/2023