HEALTH PLANS
UNIVERSITY OF UTAH

PRIOR AUTHORIZATION REQUEST FORM
ABECMA®

For authorization, please answer each question and fax this form PLUS chart notes back to the U of U Health Plans Prior Authorization Department at 888-509-8142.

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

If you have prior authorization questions, please call for assistance: University of Utah Health Employees: 855-856-5690, Individual & Family Plans : 855-869-4769, Commercial Groups: 855-859-4892, MHC 855-885-7695

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:		HCPCS Code:

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: ☐ Abecma® (idecabtagene vicleucel)

Dosing/Frequency:_____

Questions	Yes	No	Comments/Notes
1. Is the member 18 years of age or older?	☐	☐	
2. Is the requesting provider an oncologist?	☐	☐	
3. Has the member been diagnosed with multiple myeloma with measurable disease including at least one of the following: • Serum M-protein ≥1 g/dL • Urine M-protein ≥ 200 mg/24 hours • Serum free light chain (FLC) assay ≥ 10 mg/dL provided serum FLC ratio is abnormal?	☐	☐	**Please provide documentation**
4. Does the member have relapsed or refractory disease, defined as progression after ≥ 4 lines of systemic therapy? Prior therapy must include all the following: • Anti-CD38 antibody (e.g. isatuximab or daratumumab) • Proteasome inhibitor (e.g. ixazomib, bortezomib, or carfilzomib) • Immunomodulatory drug (e.g. thalidomide, pomalidomide, lenalidomide)	☐	☐	**Please provide documentation**
5. Does the member have an Eastern Cooperative Oncology Group (ECOG) performance status of 0 or 1?	☐	☐	**Please provide documentation**
6. Does documentation show an absence of active infection, including Hepatitis B, Hepatitis C, Human Immunodeficiency Virus (HIV), and influenza?	☐	☐	**Please provide documentation**

7. Does the member have adequate bone marrow reserve defined by absolute neutrophil count (ANC) ≥ 1000 and platelet count ≥ 50,000 cells/µL?	☐	☐	**Please provide documentation**
8. Does the member have any of the following: • Creatinine clearance < 45 mL/min • Alanine aminotransferase (ALT) > 2.5 times the upper limit of normal • Ejection fraction < 45% • Active inflammatory disorder • History of chimeric antigen receptor therapy (CAR-T) or other genetically modified T-cell therapy • History of allogeneic stem cell transplant?	☐	☐	**Please provide documentation**
9. For sexually active females of reproductive age, does the member have a negative pregnancy test?	☐	☐	**Please provide documentation**
10.Does the member have a presence or history of central nervous system involvement with myeloma?	☐	☐	**Please provide documentation**
10. Is the member and the requesting provider enrolled in the Abecma® REMS program?	☐	☐	
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- M033
Origination Date: 05/07/2021
Reviewed/Revised Date: 05/18/2022
Next Review Date: 05/18/2023
Current Effective Date: 06/01/2022