

**MEDICAL PHARMACY 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 801-213-1547. Failure to submit clinical documentation to support this request will result in delay and/or denial of the request.**

If you have prior authorization questions, please call for assistance: Healthy U: 855-856-5694, University of Utah Health Employees: 855-856-5690, Individual & Family Plans: 855-869-4769, Commercial Groups: 855-859-4892, MHC: 855-885-7695, Advantage U Part B: 888-605-0858

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?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Is the requesting provider an oncologist?	<input type="checkbox"/>	<input type="checkbox"/>	
3. Has the member been diagnosed with multiple myeloma with measurable disease including at least one of the following: <ul style="list-style-type: none"> <li>• Serum M-protein <math>\geq 1</math> g/dL</li> <li>• Urine M-protein <math>\geq 200</math> mg/24 hours</li> <li>• Serum free light chain (FLC) assay <math>\geq 10</math> mg/dL provided serum FLC ratio is abnormal?</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
4. Does the member have relapsed or refractory disease, defined as progression after $\geq 4$ lines of systemic therapy? Prior therapy must include all the following: <ul style="list-style-type: none"> <li>• Anti-CD38 antibody (e.g. isatuximab or daratumumab)</li> <li>• Proteasome inhibitor (e.g. ixazomib, bortezomib, or carfilzomib)</li> <li>• Immunomodulatory drug (e.g. thalidomide, pomalidomide, lenalidomide)</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
5. Does the member have an Eastern Cooperative Oncology Group (ECOG) performance status of 0 or 1?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>

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6. Does documentation show an absence of active infection, including Hepatitis B, Hepatitis C, Human Immunodeficiency Virus (HIV), and influenza?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
7. Does the member have adequate bone marrow reserve defined by absolute neutrophil count (ANC) $\geq$ 1000 and platelet count $\geq$ 50,000 cells/ $\mu$ L?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
8. Does the member have any of the following: <ul style="list-style-type: none"> <li>• Creatinine clearance &lt; 45 mL/min</li> <li>• Alanine aminotransferase (ALT) &gt; 2.5 times the upper limit of normal</li> <li>• Ejection fraction &lt; 45%</li> <li>• Active inflammatory disorder</li> <li>• History of chimeric antigen receptor therapy (CAR-T) or other genetically modified T-cell therapy</li> <li>• History of allogeneic stem cell transplant?</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
9. For sexually active females of reproductive age, does the member have a negative pregnancy test?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
10. Does the member have a presence or history of central nervous system involvement with myeloma?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
10. Is the member and the requesting provider enrolled in the Abecma <sup>®</sup> REMS program?	<input type="checkbox"/>	<input type="checkbox"/>	
<b>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.</b>			
Additional information:			
Physician Signature:			

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Policy PHARM- M033  
 Origination Date: 05/07/2021  
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