

## **MEDICARE FORM**

## **Kyprolis (carfilzomib) Medication Precertification Request**

Page 1 of 2

(All fields must be completed and legible for precertification review.)

For Michigan MMP: FAX: 1-844-241-2495 PHONE: 1-855-676-5772

For other lines of business:

Please use other form.

Note: Kyprolis is non-preferred. Bortezomib and Velcade are preferred.

Please indicate: Start of treatm		last treatment	1 1	,			
Precertification Requested By:	· ·	adt trodtmont		ne:	Fax:		
A. PATIENT INFORMATION							
First Name:		Last Name:			DOB:	DOB:	
Address:		1	City:		State:	ZIP:	
	Work Phone:		Cell Phone:		Email:		
Patient Current Weight: lbs or		l l		Allergies:			
B. INSURANCE INFORMATION							
Aetna Member ID #:		Does patient have other coverage? ☐ Yes ☐ No					
Group #:		If yes, provide ID#: Carrier Name:					
Insured:		Insured:					
Medicare: ☐ Yes ☐ No If yes, pro	vide ID #:	M	ledicaid: Yes	s 🗌 No If yes, pi	rovide ID #:		
C. PRESCRIBER INFORMATION							
First Name:		Last Name: (Check Or			e):		
Address:			City:		State:	ZIP:	
Phone: Fax:		St Lic #:	NPI #:	DEA #:		UPIN:	
Provider Email:		Office Contact Name	<b>)</b> :		Phone:		
Specialty (Check one):   Oncologis	st 🗌 Other:						
D. DISPENSING PROVIDER/ADMIN Place of Administration:  Self-administered Phys Outpatient Infusion Center Center Name: Home Infusion Center Agency Name: Administration code(s) (CPT): Address: E. PRODUCT INFORMATION Request is for: Kyprolis (carfilzo F. DIAGNOSIS INFORMATION - Plea Primary ICD Code: G. CLINICAL INFORMATION - Request For ALL Multiple Myeloma Requests (6)	mib) Dose: ase indicate primary	/ ICD code and speci Secondary ICD Co tion must be complete	☐ Physicia ☐ Specialt ☐ Name: ☐ Address: ☐ Phone: ☐ TIN: ☐ Freq fy any other where ode: ☐ ed in its entirety f	quency: re applicable. Otho	Retail Phan	macy	
Please indicate the patient's Body Surfa For once weekly treatment:  Yes No Will the patient's do Yes No Will the patient be reformed by the patient be reformed.  For twice weekly treatment: Yes No Will the patient's do Yes No Will the patient be reformed.  For Initiation Requests (clinical docum Note: Kyprolis is non-preferred. Borte Yes No Has the patient had pricent of the patient had a treatment	se exceed 70 mg/m2 eceiving more than 3 se exceed 56 mg/m2 eceiving more than 6 mentation required from the rapy with Kyprolial and failure, intoler elcade (bortezomib) dical reason(s) that the	_m² 2 (not to exceed 154 mg doses per 28 days? 2 (not to exceed 124 mg doses per 28 days? 5 for all requests): are preferred. lis within the last 365 deance, or contraindication	g per dose)? g per dose)? days? ion to any of the fo	0 (	,	for the patient's	



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Patient First Name	Patient Last Name	Patient Phone	Patient DOB				
G. CLINICAL INFORMATION (continued	d) – Required clinical information must be	completed in its entirety for	or all precertification requests.				
☐ Multiple myeloma	, ·	·	·				
Please indicate the prescribed regimen:							
☐ The requested medication in combina	tion with dexamethasone						
Yes No Is the patient's d							
•	tion with cyclophosphamide and dexametha	asone					
<del>_</del> .	tion with lenalidomide and dexamethasone						
	tion with daratumumab, lenalidomide and d						
Τ '	tion with daratumumab and dexamethason	9					
Yes No Is the patient's c							
The requested medication in combination with daratumumab and hyaluronidase-fihj and dexamethasone							
Yes No Is the patient's o							
☐ The requested medication in combination with panobinostat  The requested medication in combination with panobinostat							
•	·	~	nomodulatory agent (e.g., Revilmid)?				
☐ The requested medication in combination with pomalidomide and dexamethasone  ☐ Yes ☐ No Has the patient received at least two prior therapies including a proteasome inhibitor (PI) (e.g., Velcade) and an							
	ory agent (e.g., Revlimid)?	ig a proteasome inhibitor (Pi	) (e.g., veicade) and an				
	tion with cyclophosphamide, thalidomide, a	nd dexamethasone					
Yes No Is the patient's d	lisease relapsed or progressive?						
☐ The requested medication in combina	tion with isatuximab-irfc and dexamethasor	е					
Yes No Is the patient's disease relapsed or progressive?							
The requested medication in combination with selinexor and dexamethasone							
Yes No Is the patient's disease relapsed or progressive?							
The requested medication as a single agent							
☐ Yes ☐ No Has the patient received at least one prior therapy?							
Systemic light chain amyloidosis	hanlaamaaytia lymuhama						
☐ Waldenstrom macroglobulinemia/lymp							
For Continuation Requests (clinical docum							
Yes No Has the patient experienced	unacceptable toxicity or disease progression	on while on the current regim	ien?				
H. ACKNOWLEDGEMENT							
Request Completed By (Signature Requ	ıired):		Date: /				
Any person who knowingly files a request any insurance company by providing mate insurance act, which is a crime and subject	erially false information or conceals mate	rial information for the pur					

The plan may request additional information or clarification, if needed, to evaluate requests.