aetna®

MEDICARE FORM

Kyprolis (carfilzomib) Medication Precertification Request

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

Virginia (HMO D-SNP)
FAX: 1-833-280-5224
PHONE: 1-855-463-0933

For other lines of business:
Please use other form.

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

Please indicate: ☐ Start of treatment: Start date ____/____/____
☐ Continuation of therapy, Date of last treatment ____/____/____

Precertification Requested By: _____ Phone: _____ Fax: _____

A. PATIENT INFORMATION

First Name:	Last Name:		DOB:	
Address:		City:	State:	ZIP:
Home Phone:	Work Phone:	Cell Phone:	Email:	
Patient Current Weight: ____ lbs or ____ kgs Patient Height: ____ inches or ____ cms			Allergies:	

B. INSURANCE INFORMATION

Aetna Member ID #: _____
Group #: _____
Insured:

Does patient have other coverage? ☐ Yes ☐ No
If yes, provide ID#: _____ Carrier Name: _____
Insured:

Medicare: ☐ Yes ☐ No If yes, provide ID #:

Medicaid: ☐ Yes ☐ No If yes, provide ID #:

C. PRESCRIBER INFORMATION

First Name:		Last Name:		*(Check One):* ☐ M.D. ☐ D.O. ☐ N.P. ☐ P.A.	
Address:			City:	State:	ZIP:
Phone:	Fax:	St Lic #:	NPI #:	DEA #:	UPIN:
Provider Email:		Office Contact Name:		Phone:	

Specialty *(Check one):* ☐ **Oncologist** ☐ **Other**: _____

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration:

☐ Self-administered ☐ Physician's Office
☐ Outpatient Infusion Center Phone: _____
Center Name: _____
☐ Home Infusion Center Phone: _____
Agency Name: _____
☐ Administration code(s) (CPT): _____
Address: _____

Dispensing Provider/Pharmacy: *Patient Selected choice*

☐ Physician's Office ☐ Retail Pharmacy
☐ Specialty Pharmacy ☐ Other

Name: _____
Address: _____
Phone: _____ Fax: _____
TIN: _____ PIN: _____

E. PRODUCT INFORMATION

Request is for: ☐ **Kyprolis (carfilzomib) Dose:** _____ **Frequency:** _____

F. DIAGNOSIS INFORMATION - Please indicate primary ICD code and specify any other where applicable.

Primary ICD Code: _____ **Secondary ICD Code:** _____ **Other ICD Code:** _____

G. CLINICAL INFORMATION - Required clinical information must be completed in its entirety for all precertification requests.

For ALL Multiple Myeloma Requests (clinical documentation required for all requests):

Please indicate the patient's Body Surface Area (BSA): ____m^2

For once weekly treatment:
☐ Yes ☐ No Will the patient's dose exceed 70 mg/m2 (not to exceed 154 mg per dose)?
☐ Yes ☐ No Will the patient be receiving more than 3 doses per 28 days?

For twice weekly treatment:
☐ Yes ☐ No Will the patient's dose exceed 56 mg/m2 (not to exceed 124 mg per dose)?
☐ Yes ☐ No Will the patient be receiving more than 6 doses per 28 days?

For Initiation Requests (clinical documentation required for all requests):

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

☐ Yes ☐ No Has the patient had prior therapy with Kyprolis within the last 365 days?
☐ Yes ☐ No Has the patient had a trial and failure, intolerance, or contraindication to any of the following? (select all that apply)
☐ Bortezomib ☐ Velcade (bortezomib)

Please explain if there are any other medical reason(s) that the patient cannot use any of the following preferred products when indicated for the patient's diagnosis? (select all that apply)
☐ Bortezomib ☐ Velcade (bortezomib)

_____

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Patient First Name	Patient Last Name	Patient Phone	Patient DOB

G. CLINICAL INFORMATION *(continued)* – Required clinical information must be completed in its entirety for all precertification requests.

☐ **Multiple myeloma**

Please indicate the prescribed regimen:

☐ The requested medication in combination with dexamethasone
→ ☐ Yes ☐ No Is the patient's disease relapsed or progressive?

☐ The requested medication in combination with cyclophosphamide and dexamethasone

☐ The requested medication in combination with lenalidomide and dexamethasone

☐ The requested medication in combination with daratumumab, lenalidomide and dexamethasone

☐ The requested medication in combination with daratumumab and dexamethasone
→ ☐ Yes ☐ No Is the patient's disease relapsed or progressive?

☐ The requested medication in combination with daratumumab and hyaluronidase-fihj and dexamethasone
→ ☐ Yes ☐ No Is the patient's disease relapsed or progressive?

☐ The requested medication in combination with panobinostat
→ ☐ Yes ☐ No Has the patient received at least two prior therapies including bortezomib and an immunomodulatory agent (e.g., Revlimid)?

☐ 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 immunomodulatory agent (e.g., Revlimid)?

☐ The requested medication in combination with cyclophosphamide, thalidomide, and dexamethasone
→ ☐ Yes ☐ No Is the patient's disease relapsed or progressive?

☐ The requested medication in combination with isatuximab-irfc and dexamethasone
→ ☐ 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**

☐ **Waldenstrom macroglobulinemia/lymphoplasmacytic lymphoma**

For Continuation Requests (clinical documentation required for all requests):

☐ Yes ☐ No Has the patient experienced unacceptable toxicity or disease progression while on the current regimen?

H. ACKNOWLEDGEMENT

Request Completed By *(Signature Required):* _____ **Date:** ____/____/____

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

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