

PHARMACY REVIEW SERVICES

PHONE: (206) 901-4700

FAX: (800) 377-8853

PATIENT:			
DOB:		MEMBER #:	
PHARMACY:		PHONE #:	
PRESCRIBER:		ALT #:	
ADMIN LOCATION:		DX CODE (S):	

Abecma (idecabtagene vicleucel)**Office Administered Prior Authorization Drug Request Form**

Please provide any or all clinical chart notes along with this page

Diagnosis:☐ YES ☐ NO **Multiple Myeloma** (If YES, check all criteria that apply below)☐ YES ☐ NO Is idecabtagene vicleucel (Abecma) being used as 4th line and beyond?☐ YES ☐ NO Patient has progressed on or is intolerant to at least 5 drugs, with at least 1 from each of the following 3 drug classes:
immunomodulatory agents, proteasome inhibitors, anti-CD38 monoclonal antibodies (*please select specific therapies*)☐ lenalidomide☐ pomalidomide☐ carfilzomib☐ bortezomib☐ ixazomib☐ isatuximab☐ daratumumab☐ Other: _____

Does patient have any of the following exclusion criteria listed below:

☐ YES ☐ NO Has patient received prior CAR-T therapy or other genetically modified T cell therapy**Authorization duration:** limited to a one-time (single infusion) treatment