Kyprolis® (carfilzomib) Medication Precertification Request

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

Aetna Precertification Notification
Phone: 1-866-752-7021 (**TTY:** 711)
FAX: 1-888-267-3277

For Medicare Advantage Part B:
Please Use Medicare Request Form

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):

☐ **Multiple myeloma**
☐ Yes ☐ No Has the patient had a contraindication, intolerance or ineffective response to Velcade or its generic equivalent bortezomib?

Please indicate the prescribed regimen:
☐ The requested medication in combination with dexamethasone
→ What is the clinical setting in which the requested medication will be used? ☐ Progressive disease ☐ Refractory disease ☐ Relapsed disease ☐ Other ______________
☐ 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
→ What is the clinical setting in which the requested medication will be used? ☐ Progressive disease ☐ Refractory disease ☐ Relapsed disease ☐ Other ______________

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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.

- ☐ The requested medication in combination with daratumumab, hyaluronidase-fihj and dexamethasone
  - What is the clinical setting in which the requested medication will be used? ☐ Progressive disease ☐ Refractory disease ☐ Relapsed disease ☐ Other ______
- ☐ The requested medication in combination with pomalidomide and dexamethasone
  - What is the clinical setting in which the requested medication will be used? ☐ Relapsed disease ☐ Progressive disease ☐ Other
- ☐ The requested medication in combination with cyclophosphamide, thalidomide, and dexamethasone
  - What is the clinical setting in which the requested medication will be used? ☐ Relapsed disease ☐ Progressive disease ☐ Other
- ☐ The requested medication in combination with isatuximab-irfc and dexamethasone
  - What is the clinical setting in which the requested medication will be used? ☐ Progressive disease ☐ Refractory disease ☐ Relapsed disease ☐ Other ______
- ☐ The requested medication in combination with selinexor and dexamethasone
  - What is the clinical setting in which the requested medication will be used? ☐ Progressive disease ☐ Relapsed disease ☐ Other
- ☐ The requested medication will be used as a single agent
  - ☐ Yes ☐ No Has the patient received at least one prior therapy?
- ☐ The requested medication in combination with lenalidomide
  - ☐ Yes ☐ No Will the requested medication be used as a maintenance therapy for symptomatic disease?
- ☐ The requested medication in combination with bendamustine and dexamethasone
  - ☐ Yes ☐ No Has the patient received more than 3 prior therapies?
  - What is the clinical setting in which the requested medication will be used? ☐ Refractory disease ☐ Relapsed disease ☐ Other
- ☐ The requested medication in combination with venetoclax and dexamethasone
  - What is the clinical setting in which the requested medication will be used? ☐ Relapsed disease ☐ Progressive disease ☐ Other
  - ☐ Yes ☐ No ☐Unknown Does the patient have a documented t(11:14) translocation?
- ☐ Other ______

☐ **Systemic light chain amyloidosis**
- ☐ Yes ☐ No What is the clinical setting in which the requested medication will be used? ☐ Relapsed disease ☐ Refractory disease ☐ Other

☐ **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.