aetna®

# MEDICARE FORM

# Kyprolis (carfilzomib) Medication Precertification Request



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

**For Medicare Advantage Part B:**
**Phone: 1-866-503-0857 (TTY: 711)**
**FAX: 1-844-268-7263**

**For other lines of business:**
Please use other form.

**Note: Kyprolis is non-preferred. Bortezomib is 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: _____
City: _____ State: _____ ZIP: _____
Phone: _____ Fax: _____
**TIN:** _____ PIN: _____
NPI: _____

**Dispensing Provider/Pharmacy:** *Patient Selected choice*

☐ Physician's Office ☐ Retail Pharmacy
☐ Specialty Pharmacy ☐ Other
Name: _____
Address: _____
City: _____ State: _____ ZIP: _____
Phone: _____ Fax: _____
**TIN:** _____ PIN: _____
NPI: _____

## E. PRODUCT INFORMATION

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

## 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 is 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 bortezomib?
☐ Yes ☐ No Will Kyprolis be used in combination with bortezomib?
Please explain if there are any other medical reason(s) that the patient cannot use bortezomib when indicated for the patient's diagnosis?

_____

***Continued on next page***

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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.