KAISER PERMANENTE

10/3/2022

**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 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