AvMed

MEDICAL PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

<u>Directions:</u> The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request. All other information may be filled in by office staff; <u>fax to 1-877-535-1391</u>. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. <u>If information provided is not complete, correct, or legible, authorization can be delayed</u>.

<u>For Medicare Members:</u> Medicare Coverage for outpatient (Part B) drugs is outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals. In addition, National Coverage Determination (NCD) and Local Coverage Determinations (LCDs) may exist and compliance with these policies is required where applicable. They can be found at: https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx. Additional indications may be covered at the discretion of the health plan.

<u>Drug Requested</u>: Carvykti[™] (ciltacabtagene autoleucel) (J9999/C9399) (Medical)

MEMBER & PRESCRIBER INF	TORMATION: Authorization may be delayed if incomplete.		
Member Name:			
Member AvMed #:	Date of Birth:		
Prescriber Name:			
Prescriber Signature:	Date:		
Office Contact Name:			
Phone Number:	Fax Number:		
NPI #:			
DRUG INFORMATION: Authoriz			
Drug Name/Form/Strength:			
Dosing Schedule:	Length of Therapy:		
Diagnosis:	ICD Code, if applicable:		
Weight (if applicable):	Date weight obtained:		
	the timeframe does not jeopardize the life or health of the member m function and would not subject the member to severe pain.		

A. Quantity Limit (max daily dose) [NDC Unit]:

• 1 dose of up to 100 million autologous CAR-positive viable T-cells (supplied as an infusion bag in a metal cassette)

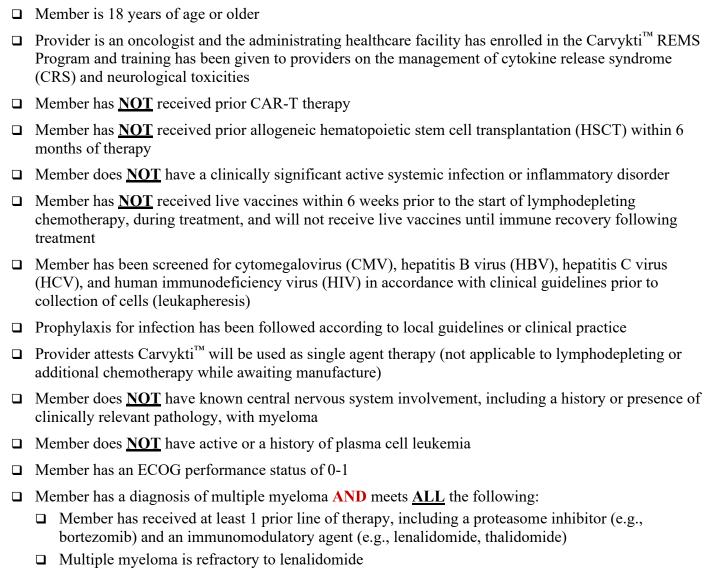
B. Max Units (per dose and over time) [HCPCS Unit]:

• 1 dose of up to 100 million autologous CAR-positive viable T-cells

(Continued on next page)

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

<u>Autl</u>	<u> 10riza</u>	<u>ation</u>	<u>Crite</u>	<u>ria</u> :



(Continued on next page)

Reauthorization Criteria - Coverage cannot be renewed

Med	Medication being provided by: Please check applicable box below.		
	Location/site of drug administration:		
	NPI or DEA # of administering location:		
	<u>OR</u>		
	Specialty Pharmacy – Proprium Rx		
review treatm	gent reviews: Practitioner should call AvMed Pre-Authorization Department if they believe a standard would subject the member to adverse health consequences. AvMed's definition of urgent is a lack of ent that could seriously jeopardize the life or health of the member or the member's ability to regain turn function.		
*:	Use of samples to initiate therapy does not meet step edit/preauthorization criteria.** vious therapies will be verified through pharmacy paid claims or submitted chart notes.		