MEDICARE FORM
Kyprolis (carfilzomib) Medication Precertification Request

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

For Medicare Advantage Part B:
For other lines of business:
Please use commercial form.

Note: Kyprolis is non-preferred. Bortezomib is preferred.

Would you like to use electronic prior authorization? Consider using **Availity**, our electronic prior authorization portal. Learn more about **Availity** from the links in the table below.

For phone or fax requests, refer to the table below for routing information. To determine which box to use, refer to the patient's Aetna ID card. State specific special needs and Medicare-Medicaid Plans may be designated on the front of the ID card or in the website URL on the back of the card. If you don't see your specific plan listed, call the number on the back of the member's ID card to confirm routing information.

For **Aetna Medicare Advantage** and **Allina Health Aetna Medicare** members send request to: **Phone:** 1-866-503-0857 **(TTY:** 711**)** **Fax:** 1-844-268-7263 **Availity:** https://www.aetna.com/health-care-professionals/resource-center/availity.html
For Aetna Medicare Advantage **Virginia Dual Eligible Special Needs Plans** (HMO D-SNP) send request to: **Phone:** 1-855-463-0933 **Fax:** 1-833-280-5224 **Availity:** https://www.aetnabetterhealth.com/virginia-hmosnp/providers/portal
For Aetna Assure Premier Plus Medicare Advantage **New Jersey Dual Eligible Special Needs Plans** (HMO D-SNP) send request to: **Phone:** 1-844-362-0934 **Fax:** 1-833-322-0034 **Availity:** https://www.aetnabetterhealth.com/new-jersey-hmosnp/providers/portal.html
For Aetna Better Health of **Illinois Premier Medicare Medicaid Plan** (MMP) send request to: **Phone:** 1-866-600-2139 **FAX:** 1-855-320-8445 **Availity:** https://www.aetnabetterhealth.com/illinois/providers/portal
For Aetna Better Health of **Ohio Premier Medicare Medicaid Plan** (MMP) send request to: **Phone:** 1-855-364-0974 **Fax:** 1-855-734-9389 **Availity:** https://www.aetnabetterhealth.com/ohio/providers/portal
For Aetna Better Health of **Michigan Premier Medicare Medicaid Plan** (MMP) send request to: **Phone:** 1-855-676-5772 **Fax:** 1-844-241-2495 **Availity:** https://www.aetnabetterhealth.com/michigan/providers/portal.html

aetna®

MEDICARE FORM
Kyprolis (carfilzomib) Medication Precertification Request

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

For Medicare Advantage Part B:
For other lines of business:
Please use commercial 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 #: _____	Does patient have other coverage? ☐ Yes ☐ No
Group #: _____	If yes, provide ID#: _____ Carrier Name: _____
Insured:	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 Will Kyprolis be used in combination with bortezomib?
☐ Yes ☐ No Has the patient had a trial and failure of bortezomib?
→ When was the member's trial and failure of bortezomib? _____
→ Please describe the nature of the failure of bortezomib _____

Continued on next page

MEDICARE FORM
Kyprolis (carfilzomib) Medication Precertification Request

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

For Medicare Advantage Part B:
For other lines of business:
Please use commercial form.

Note: Kyprolis is non-preferred. Bortezomib is preferred.

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.

For Initiation Requests *continued* (clinical documentation required for all requests):

☐ Yes ☐ No Has the patient had an adverse reaction to bortezomib?
- When was the member's adverse reaction to bortezomib? _____
- Please describe the nature of the adverse reaction to bortezomib _____

Please explain if there are any contraindications or other medical reason(s) that the patient cannot use bortezomib when indicated for the patient's diagnosis?

_____

☐ **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.