



Sarclisa® (isatuximab-irfc)
Medication Precertification Request

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(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:			
Address:		City:		State:	ZIP:
Home Phone:		Work Phone:		Cell Phone:	
DOB:	Allergies:			Email:	
Current Weight: _____ lbs or _____ kgs		Height: _____ inches or _____ cms			

B. INSURANCE INFORMATION

Aetna Member ID #: _____		Does patient have other coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Group #: _____		If yes, provide ID#: _____ Carrier Name: _____	
Insured: _____		Insured: _____	
Medicare: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide ID #: _____		Medicaid: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide ID #: _____	

C. PRESCRIBER INFORMATION

First Name:		Last Name:		(Check One): <input type="checkbox"/> M.D. <input type="checkbox"/> D.O. <input type="checkbox"/> N.P. <input type="checkbox"/> P.A.	
Address:		City:		State:	ZIP:
Phone:	Fax:	St Lic #:	NPI #:	DEA #:	UPIN:
Provider Email:		Office Contact Name:		Phone:	
Specialty (Check one): <input type="checkbox"/> Oncologist <input type="checkbox"/> Other: _____					

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration:		Dispensing Provider/Pharmacy: Patient Selected choice			
<input type="checkbox"/> Self-administered	<input type="checkbox"/> Physician's Office	<input type="checkbox"/> Physician's Office		<input type="checkbox"/> Retail Pharmacy	
<input type="checkbox"/> Outpatient Infusion Center	Phone: _____	<input type="checkbox"/> Specialty Pharmacy		<input type="checkbox"/> Other: _____	
Center Name: _____		Name: _____			
<input type="checkbox"/> Home Infusion Center	Phone: _____	Address: _____			
Agency Name: _____		Phone: _____		Fax: _____	
<input type="checkbox"/> Administration code(s) (CPT): _____		TIN: _____		PIN: _____	
Address: _____					

E. PRODUCT INFORMATION

Request is for Sarclisa (isatuximab-irfc) 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 Requests (clinical documentation required for all requests):
 Yes No Does the patient have a documented diagnosis of multiple myeloma?

For Initiation Requests (clinical documentation required for all requests):
 Please select the prescribed regimen:
 The requested drug in combination with pomalidomide and dexamethasone
 ↳ Yes No Has the patient received at least two prior therapies for multiple myeloma, including lenalidomide and a proteasome inhibitor (e.g., Velcade)?
 The requested drug in combination with carfilzomib and dexamethasone
 ↳ Yes No Has the patient received at least one prior line of therapy for multiple myeloma?
 The requested drug in combination with bortezomib, lenalidomide and dexamethasone
 ↳ Yes No Will the requested drug be used as primary therapy?
 ↳ Yes No Is the patient a transplant candidate?

For Continuation Requests (clinical documentation required for all requests):
 Yes No Is there evidence of unacceptable toxicity or disease progression while receiving the requested drug on the current regimen?



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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.