



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

FAX: 1-888-267-3277

For Medicare Advantage Part B:

Phone: 1-866-503-0857

FAX: 1-844-268-7263

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: <i>Patient Selected choice</i>			
<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?

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?

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.