JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE

Breyanzi

Prior Authorization Request

Your patient's benefit plan requires prior authorization for certain medications. In order to make appropriate medical necessity determinations, your patient's diagnosis and other clinical information is required. **Please complete the information requested on the form below and fax this form along with supporting clinical documentation to Priority Partners, toll-free at 1-866-212-4756 to initiate the review process.** If you have questions regarding the prior authorization please contact Priority Partners at 888-819-1043 Option 4**.**

Patient's Name: _____ **Date**: _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____

Referring Provider Info: ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Rendering Provider Info: ❑ **Same as Referring Provider** ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Required Demographic Information:

Patient Weight: _____kg

Patient Height: _____*cm*

Please indicate the place of service for the requested drug:

❑ *Ambulatory Surgical* ❑ *Home* ❑ *Off Campus Outpatient Hospital*
❑ *On Campus Outpatient Hospital* ❑ *Office*

Drug Information:

Strength/Measure _____ *Units* ❑ ml ❑ Gm ❑ mg ❑ ea ❑ Un
Directions(sig) _____ *Route of administration* _____
Dosing frequency _____

What is the ICD-10 code? _____

Send completed form to: Priority Partners Fax: 1-866-212-4756

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received the fax in error, please immediately notify the sender by telephone and destroy the original fax message. Breyanzi SGM 4513-A – 06/2023.

Priority Partners ● 7231 Parkway Drive Suite 100 ● Hanover, MD 21076
Phone: 888-819-1043 ● Fax: 1-866-212-4756 ● www.jhhc.com

Criteria Questions:

1. What is the diagnosis?

❒ Adult Large B-cell lymphoma, *Continue to #10*

❒ Other, *Continue to #10*

10. Is the patient 18 years of age or older?

❒ Yes, *Continue to #11*

❒ No, *Continue to #11*

11. Does the patient have any of the following B-cell lymphoma subtypes?

❒ Diffuse large B-cell lymphoma (DLBCL) [including DLBCL NOS, follicular lymphoma grade 3, DLBCL arising from indolent lymphomas], *Continue to #12*

❒ High grade B-cell lymphoma (including high-grade B-cell lymphoma with translocations of MYC and BCL2 and/or BCL6 [double/triple hit lymphoma], high-grade B-cell lymphoma, not otherwise specified), *Continue to #12*

❒ Primary mediastinal large B-cell lymphoma, *Continue to #12*

❒ Acquired immunodeficiency syndrome (AIDS)-related B-cell lymphomas (including AIDS-related diffuse large B-cell lymphoma, primary effusion lymphoma, and human herpesvirus 8 (HHV8)-positive diffuse large B-cell lymphoma, not otherwise specified), *Continue to #13*

❒ Monomorphic post-transplant lymphoproliferative disorder (B-cell type), *Continue to #13*

❒ Other, *No Further Questions*

12. Has the patient received prior treatment with first-line chemoimmunotherapy (e.g., RCHOP [rituximab, cyclophosphamide, doxorubicin, vincristine, prednisone])? ***Action Required: If 'Yes', please attach chart notes, medical records or claims history supporting previous lines of therapy.***

❒ Yes, *Continue to #14*

❒ No, *Continue to #13*

13. Has the patient received prior treatment with two or more lines of systemic therapy? ***Action Required: If 'Yes', please attach chart notes, medical records or claims history supporting previous lines of therapy.***

❒ Yes, *Continue to #14*

❒ No, *Continue to #14*

14. Does the patient have primary central nervous system lymphoma?

❒ Yes, *Continue to #15*

❒ No, *Continue to #15*

15. Does the patient have adequate and stable kidney, liver, pulmonary and cardiac function?

❒ Yes, *Continue to #16*

❒ No, *Continue to #16*

16. Does the patient have active hepatitis B, active hepatitis C, or any active uncontrolled infection?

❒ Yes, *Continue to #17*

❒ No, *Continue to #17*

17. Does the patient have active graft versus host disease?

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❒ Yes, *Continue to #18*

❒ No, *Continue to #18*

18. Does the patient have an active inflammatory disorder?

❒ Yes, *Continue to #19*

❒ No, *Continue to #19*

19. Does the patient have an Eastern Cooperative Oncology Group (ECOG) performance status of 0 to 2 (the patient is ambulatory and capable of all self-care but unable to carry out any work activities.Up and about more than 50% of waking hours)?

❒ Yes, *Continue to #20*

❒ No, *Continue to #20*

20. Has the patient received a previous treatment course of the requested medication or another CD19-directed chimeric antigen receptor (CAR) T-cell therapy (e.g., Yescarta, Kymriah)? (Internal note: Operations should check the patient's PA history to ensure the patient has not had one previous course of Breyanzi or another CD19-directed CAR T-cell therapy.)

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X_____

Prescriber or Authorized Signature **Date (mm/dd/yy)**

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