Kymriah

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 (POS Code 24)*
❑ *Home (POS Code 12)*
❑ *Off Campus Outpatient Hospital (POS Code 19)*
❑ *On Campus Outpatient Hospital (POS Code 22)*
❑ *Office (POS Code 11)*

Drug Information:

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

Criteria Questions:

1. Has the patient previously received a treatment course of Kymriah or another CD19-directed chimeric antigen receptor (CAR) T-cell therapy (e.g., Yescarta)?
❒ Yes, *Continue to 2*
❒ No, *Continue to 2*

2. Does the patient have adequate and stable kidney, liver, pulmonary and cardiac function?
❒ Yes, *Continue to 3*
❒ No, *Continue to 3*

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

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❒ Yes, *Continue to 4*
❒ No, *Continue to 4*

4. Does the patient have active graft versus host disease?
❒ Yes, *Continue to 5*
❒ No, *Continue to 5*

5. Does the patient have an active inflammatory disorder?
❒ Yes, *Continue to 6*
❒ No, *Continue to 6*

6. What is the diagnosis?

❒ Acute lymphoblastic leukemia (ALL), *Continue to 7*

❒ Diffuse large B-cell lymphoma (DLBCL) arising from follicular lymphoma, *Continue to 15*

❒ Follicular lymphoma (FL), *Continue to 15*

❒ Histologic transformation of indolent lymphomas to DLBCL, *Continue to 15*

❒ Diffuse large B-cell lymphoma, *Continue to 15*
❒ 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 15*
❒ Human immunodeficiency virus (HIV)-related B-cell lymphomas (including HIV-related diffuse large B-cell lymphoma, primary effusion lymphoma, and human herpesvirus 8 (HHV8)-positive diffuse large B-cell lymphoma, not otherwise specific), *Continue to 15*

❒ Monomorphic post-transplant lymphoproliferative disorder (B-cell type), *Continue to 15*

❒ Other, please specify. _____, *No Further Questions*

7. Does the patient have B-cell precursor acute lymphoblastic leukemia?
❒ Yes, *Continue to 8*
❒ No, *Continue to 8*

8. Does the patient have CD19 tumor expression in bone marrow or peripheral blood? ***ACTION REQUIRED***: If Yes, attach chart note(s) or test results confirming CD19 tumor expression in bone marrow or peripheral blood.

❒ Yes ***ACTION REQUIRED****: Submit supporting documentation, Continue to 9*

❒ No*, Continue to 9*

❒ Unknown or testing has not been completed*, Continue to 9*

9. Does the patient have at least 5% lymphoblasts in the bone marrow? ***ACTION REQUIRED***: If Yes, attach results of testing or analysis confirming at least 5% lymphoblasts in the bone marrow.

❒ Yes ***ACTION REQUIRED****: Submit supporting documentation, Continue to 10*

❒ No*, Continue to 10*

❒ Unknown or testing has not been completed*, Continue to 10*

10. What is the Philadelphia chromosome status for the patient's disease?

❒ Philadelphia chromosome-positive disease, *Continue to 11*

❒ Philadelphia chromosome-negative disease, *Continue to 12*

❒ Unknown, *Continue to 11*

11. Does the patient meet any of the following? ***ACTION REQUIRED***: Attach chart notes, medical record documentation or claims history supporting previous lines of therapy.

❒ Patient has refractory disease ***ACTION REQUIRED****: Submit supporting documentation, Continue to 13*
❒ Patient has had 2 or more relapses and has failed at least 2 tyrosine kinase inhibitors (TKIs) (e.g., bosutinib, dasatinib, imatinib, nilotinib, ponatinib) ***ACTION REQUIRED****: Submit supporting documentation, Continue to 13*
❒ Patient has relapsed disease and is TKI intolerant ***ACTION REQUIRED****: Submit supporting documentation, Continue to 13*
❒ Patient has experienced a relapse post-hematopoietic stem cell transplant (HSCT) ***ACTION REQUIRED****: Submit supporting documentation, Continue to 13*

❒ None of the above*, Continue to 13*

12. Does the patient meet any of the following? ***ACTION REQUIRED***: Attach chart notes, medical record documentation or claims history supporting previous lines of therapy.

❒ Patient has refractory disease ***ACTION REQUIRED****: Submit supporting documentation, Continue to 13*

❒ Patient has had 2 or more relapses ***ACTION REQUIRED****: Submit supporting documentation, Continue to 13*

❒ None of the above*, Continue to 13*

13. What is the patient's Karnofsky (age 16 years or older) or Lansky (age younger than 16 years) performance status?

_____%, *Continue to 14*

14. What is the patient's age?
_____ years, *No Further Questions*

15. Has the patient received prior treatment with two or more lines of systemic therapy? ***ACTION REQUIRED***: If Yes, attach chart notes, medical record documentation or claims history supporting previous lines of therapy.
❒ Yes, *Continue to 16*
❒ No, *Continue to 16*

16. Does the patient have primary central nervous system lymphoma?
❒ Yes, *Continue to 17*
❒ No, *Continue to 17*

17. Does the patient have an Eastern Cooperative Oncology Group (ECOG) performance status of 0 to 2 (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 18*
❒ No, *Continue to 18*

18. What is the patient's age?
_____ years, *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)**

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

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