Tecartus

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 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*_____

What is the ICD-10 code? _____

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

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

Criteria Questions:

1. Has the patient received a previous treatment course of Tecartus (brexucabtagene autoleucel) or another CD19-directed chimeric antigen receptor (CAR) T-cell therapy?
❒ Yes, *Continue to 2*
❒ No, *Continue to 2*

2. What is the patient's age?
_____years_____months, *Continue to 3*

3. 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 4*
❒ No, *Continue to 4*

4. Does the patient have adequate and stable kidney, liver, pulmonary and cardiac function?
❒ Yes, *Continue to 5*
❒ No, *Continue to 5*

5. Does the patient have active hepatitis B, active hepatitis C, or any active uncontrolled infection?
❒ Yes, *Continue to 6*
❒ No, *Continue to 6*

6. Does the patient have an active inflammatory disorder?
❒ Yes, *Continue to 7*
❒ No, *Continue to 7*

7. What is the diagnosis?
❒ Mantle cell lymphoma, *Continue to 8*
❒ Acute lymphoblastic leukemia (ALL), *Continue to 11*
❒ Other, please specify. _____, *No Further Questions*

8. What is the clinical setting in which the requested medication will be used?
❒ Relapsed disease, *Continue to 9*
❒ Refractory disease, *Continue to 9*
❒ Other, please specify. _____, *Continue to 9*

9. Has the patient previously received chemoimmunotherapy? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical records or claims history supporting previous lines of therapy.
❒ Yes, *Continue to 10*
❒ No, *Continue to 10*

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10. Has the patient previously received a bruton tyrosine kinase inhibitor (e.g., zanubrutinib)? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical records or claims history supporting previous lines of therapy.
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

11. Has the patient received a previous treatment course with any prior CD19 directed therapy other than blinatumomab (Blincyto)?
❒ Yes, *Continue to 12*
❒ No, *Continue to 12*

12. Does the patient have B-cell precursor acute lymphoblastic leukemia?
❒ Yes, *Continue to 13*
❒ No, *Continue to 13*

13. Does the patient have morphological disease in the bone marrow (greater than or equal to 5% blasts)? ***ACTION REQUIRED***: If Yes, attach results of testing or analysis confirming 5% or greater blasts in the bone marrow.

❒ Yes, *Continue to 14*

❒ No, *Continue to 14*

❒ Unknown or testing has not been completed, *Continue to 14*

14. Does the patient have active graft versus host disease?
❒ Yes, *Continue to 15*
❒ No, *Continue to 15*

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

❒ Philadelphia chromosome-positive disease, *Continue to 17*

❒ Philadelphia chromosome-negative disease, *Continue to 16*

❒ Unknown, *Continue to 16*

16. 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 primary refractory disease, *No Further Questions*

❒ Patient has had first relapse with remission of 12 months or less, *No Further Questions*
❒ Patient has relapsed or refractory disease after at least 2 previous lines of systemic therapy, *No Further Questions*
❒ Patient has relapsed or refractory disease after allogeneic stem cell transplant (allo-SCT), *No Further Questions*

❒ None of the above, *No Further Questions*

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17. 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 relapsed or refractory disease despite treatment with at least 2 different tyrosine kinase inhibitors (TKIs) (e.g., bosutinib, dasatinib, imatinib, nilotinib, ponatinib), *No Further Questions*

❒ Patient is intolerant to TKI therapy, *No Further Questions*

❒ None of the above, *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 Priority Partners.

X_____

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

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