Yescarta

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 _____

What is the ICD-10 code? _____

Criteria Questions:

1. Has the patient previously received one complete treatment course of Yescarta or another CD19-directed chimeric antigen receptor (CAR) T-cell therapy (e.g., Breyanzi, Kymriah)?

❒ Yes, *Continue to 2*
❒ No, *Continue to 2*

2. What is the patient's age?

❒ Less than 18 years of age, *Continue to 7*
❒ 18 years of age or older, *Continue to 3*

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

3. What is the diagnosis?

❒ Diffuse large B-cell lymphoma (DLBCL) arising from follicular lymphoma, *Continue to 6*

❒ Histologic transformation of indolent lymphomas to DLBCL, *Continue to 6*

❒ Diffuse large B-cell lymphoma (DLBCL), *Continue to 4*

❒ Primary mediastinal large B-cell lymphoma, *Continue to 4*

❒ High-grade B-cell lymphoma (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 4*

❒ 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 specified), *Continue to 4*

❒ Monomorphic post-transplant lymphoproliferative disorder (B-cell type), *Continue to 4*

❒ Follicular lymphoma, *Continue to 6*

❒ Extranodal marginal zone lymphoma of the stomach (gastric MALT), *Continue to 6*

❒ Extranodal marginal zone lymphoma of nongastric sites (nongastric MALT), *Continue to 6*

❒ Nodal marginal zone lymphoma, *Continue to 6*

❒ Splenic marginal zone lymphoma, *Continue to 6*

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

4. 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 10*

❒ No, *Continue to 5*

5. 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 10*

❒ No, *Continue to 10*

6. 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 10*

❒ No, *Continue to 10*

7. Is this requested for pediatric primary mediastinal large B-cell lymphoma?

❒ Yes, *Continue to 8*

❒ No, *Continue to 8*

8. Has the patient received prior therapy with at least two prior chemoimmunotherapy regimens (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 9*

❒ No, *Continue to 9*

9. Has the patient achieved partial response?

Priority Partners ● 7231 Parkway Drive Suite 100 ● Hanover, MD 21076

Phone: 888-819-1043 ● Fax: 1-866-212-4756 ● www.hopkinshealthplans.org

❒ Yes, *Continue to 10*
❒ No, *Continue to 10*

10. Does the patient have adequate and stable kidney, liver, pulmonary and cardiac function?
❒ Yes, *Continue to 11*
❒ No, *Continue to 11*

11. Does the patient have active hepatitis B, active hepatitis C, or a clinically significant active systemic infection?
❒ Yes, *Continue to 12*
❒ No, *Continue to 12*

12. Does the patient have an active inflammatory disorder?
❒ Yes, *Continue to 13*
❒ No, *Continue to 13*

13. Does the patient have primary central nervous system lymphoma?
❒ Yes, *Continue to 14*
❒ No, *Continue to 14*

14. 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, *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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