peach state health plan

Brexucabtagene autoleucel (Tecartus)
Prior Authorization Form/Prescription

Telephone: (800) 514-0083 option 2
Fax: (866) 374-1579

Date: _____ Date Medication Required: _____
Ship to: ❍ Physician ❍ Patient's Home ❍ Other _____

Patient Information

*Last Name:	*First Name:	Middle:	*DOB: ____/____/_____
Address:	City:	State:	Zip:
Daytime Phone:	Evening Phone:	*Sex: ☐ Male ☐ Female	

Insurance Information (*Attach copies of cards*)

*Primary Insurance:		Secondary Insurance:	
*ID #	Group #	ID #	Group #
City:	State:	City:	State:

Physician Information

*Name:	*Specialty:	NPI:	
Address:	City:	State:	Zip:
*Phone #:	Secure Fax #:	Office Contact:	

Procedural Hospital

*Hospital Name:

Primary Diagnosis

*ICD-10 Code: _____

☐Mantle cell lymphoma (MCL) ☐Acute lymphoblastic leukemia (ALL) ☐Other: _____

Prescription Information

MEDICATION	STRENGTH	*DIRECTIONS	QUANTITY	REFILLS
Tecartus (brexucabtagene autoleucel)				

Clinical Information

***** *Please submit supporting clinical documentation* *****

* **THERAPY TYPE (choose one):** ☐INITIAL THERAPY ☐CONTINUATION OF THERAPY - Therapy start date: _____

1. Please document the following patient information:
   a. Weight: _____ kg
   b. Recent (within last 30 days) absolute lymphocyte count (ALC): _____ cells/µL, date: _____
2. Is Tecartus prescribed by or in consultation with an oncologist or hematologist? ☐Yes ☐No
3. Is disease relapsed or refractory? ☐Yes ***Mark all that apply*** ☐No
   a. *If yes and ALL*, is relapsed or refractory disease defined as any of the following? ☐Yes ***Mark all that apply*** ☐No
      ☐Primary refractory disease
      ☐First relapse if first remission ≤ 12 months
      ☐Relapsed or refractory disease after 2 or more lines of systemic therapy: _____
      ☐Relapsed following allogenic stem cell transplantation (allo-SCT) ≥ 100 days from allo-SCT at the time of Tecartus infusion
      ☐Other: _____
4. Does patient have history of or current central nervous system (CNS) disease or CNS disorder? ☐Yes ***Mark all that apply*** ☐No
   ☐CNS lymphoma ☐Dementia ☐Cerebellar disease ☐Cerebrovascular ischemia/hemorrhage
   ☐Seizure disorder ☐Cerebral edema ☐Detectable cerebrospinal fluid malignant cells or brain metastases
   ☐Posterior reversible encephalopathy syndrome ☐Autoimmune disease with CNS involvement: _____
   ☐Other: _____
   a. *If yes and MCL*, is CNS disease or disorder detected by magnetic resonance imaging (MRI)? ☐Yes ☐No
5. Has patient previously been treated with CAR T-cell immunotherapy? ☐Yes ***Mark all that apply*** ☐No
   ☐Abecma ☐Breyanzi ☐Kymriah ☐Yescarta ☐Other: _____
6. Is Tecartus prescribed concurrently with other CAR T-cell immunotherapy? ☐Yes ***Mark all that apply*** ☐No
   ☐Abecma ☐Breyanzi ☐Kymriah ☐Yescarta ☐Other: _____

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7. **If MCL,**
   a. Has patient previously received 2 to 5 prior regimens that included all of the following? ☐Yes **Mark all that apply** ☐No
      ☐Anthracycline (e.g., doxorubicin) or bendamustine-containing chemotherapy: _____
      ☐Anti-CD20 monoclonal antibody therapy (e.g., Rituxan): _____
      ☐Bruton tyrosine kinase (BTK) inhibitor (e.g., Imbruvica, Calquence, Brukinsa): _____
      ☐Other: _____
   b. Does patient have a history of allogeneic stem cell transplantation? ☐Yes ☐No
8. **If ALL,**
   a. Is disease B-cell precursor ALL? ☐Yes ☐No
   b. Does patient have CNS-3 disease as defined as detectable cerebrospinal blast cells in a sample of CSF with ≥ 5 white blood cells (WBCs) per mm^3? ☐Yes: _____ WBCs per mm^3 ☐No
   c. Does patient have CNS-2 disease as defined as CSF blast cells with < 5 WBCs per mm^3? ☐Yes: _____ WBCs per mm^3 ☐No
      i. *If yes*, is there documentation of no clinically evident neurological changes? ☐Yes ☐No
   d. Is disease Philadelphia chromosome positive? ☐Yes ☐No
   e. Has patient failed 2 tyrosine kinase inhibitors at up to maximally indicated doses?
      ☐Yes **Mark all that apply** ☐No ☐Contraindicated/intolerant
      ☐Imatinib ☐Sprycel ☐Tasigna ☐Bosulif ☐Iclusig ☐Other: _____
   f. Has patient been previously treated with Blincyto? ☐Yes ☐No
      i. *If* yes, is there documentation of CD19 tumor expression on blasts obtained from bone marrow or peripheral blood after completion of the most recent prior line of therapy? ☐Yes ☐No

Complete this section ONLY for indications <u>other</u> than those listed above:

9. Has patient tried and failed, or is contraindicated to, accepted standards of care? ☐Yes ☐No
   If yes, submit documentation and answer the following:
   a. Please list all previous therapies: _____
   b. Was patient adherent to previously tried therapies? ☐Yes ☐No ☐No, patient intolerant to drug

Physician's Signature: _____ Date: _____ ☐DAW

INFORMATION BELOW IS TO BE COMPLETE BY THE HEALTH PLAN/ EPS PA STAFF

Authorization Information

* **Authorization number:**	* **Decision Due Date:**
***J-Code:**	* **Coverage:** ❑ State excludes ❑ COB (secondary)
* **Line of Business:** ❑ Commercial ❑ Health Insurance Marketplace ❑ Medicaid ❑ Medicare	* **Benefit:** ❑ Medical ❑ Pharmacy

* **Criteria:**
❑ Centene Policy
Date Policy last reviewed/approved by plan (we want to be sure we are using the version approved by your plan): _____

❑ State Specific (please include policy)

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❑ Medicare Local Coverage Decision (LCD) specific for your region (please include policy of link to LCD)

❑ Medicare National Coverage Decision (NCD) (please include policy of link to NCD)