peach state health plan

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

Lisocabtagene maraleucel (Breyanzi)
Prior Authorization Form/Prescription

*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: _____

☐ Diffuse large B-cell lymphoma (DLBCL) ☐ Primary mediastinal Large B-Cell Lymphoma (PMBCL)
☐ Transformed follicular Lymphoma (TFL) to DLBCL ☐ Transformed nodal marginal zone Lymphoma (MZL) to DLBCL
☐ Transformed gastric mucosa-associated lymphoid tissue (MALT) lymphoma to DLBCL ☐ AIDS-related primary effusion lymphoma
☐ Transformed nongastric MALT lymphoma (noncutaneous) to DLBCL ☐ Transformed splenic marginalized zone lymphoma to DLBCL
☐ High-grade B-cell lymphoma: _____ ☐ Monomorphic post-transplant lymphoproliferative disorders (B-cell type)
☐ Other: _____

Prescription Information

MEDICATION	STRENGTH	*DIRECTIONS	QUANTITY	REFILLS
Breyanzi (lisocabtagene maraleucel)				

Clinical Information ***** *Please submit supporting clinical documentation* *****

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

1. Please document patient's weight: _____ kg
2. Is Breyanzi prescribed by or in consultation with an oncologist or hematologist? ☐ Yes ☐ No
3. Is disease relapsed or refractory? ☐ Yes ☐ No
4. Does patient have primary central nervous system (CNS) disease? ☐ Yes ☐ No
5. Has patient previously received ≥ 2 prior systemic therapies that included both of the following? ☐ Yes **Mark all that apply** ☐ No
   ☐ Anthracycline – containing regimen (e.g., doxorubicin): _____
   ☐ Anti-CD20 monoclonal antibody therapy (e.g., rituximab): _____
6. Has patient previously been treated with CAR T-cell immunotherapy (e.g. Kymriah, Yescarta)? ☐ Yes: _____ ☐ No
7. Is Breyanzi prescribed concurrently with other CAR T-cell immunotherapy (e.g. Kymriah, Yescarta)? ☐ Yes ☐ No
8. **If High-grade B-cell lymphoma**, do any of the following apply to patient's disease? ☐ Yes **Mark all that apply** ☐ No
   ☐ Translocations of MYC and BCL2 ☐ Translocations of MYC and BCL6 ☐ Translocations of MYC and BCL2 and BCL6
   ☐ Other: _____

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

Please continue to page 2.

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If yes, submit documentation and answer the following:

a. Please list all previous therapies: _____

Patient Name: _____ DOB: _____

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)

❑ 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)