peach state health plan

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

Axicabtagene ciloleucel (Yescarta)
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 and Administrating Hospital

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

Procedural Hospital

*Hospital Name:

Primary Diagnosis

*ICD-10 Code: _____

☐Large B-cell lymphoma (LBCL) ☐Follicular lymphoma (FL) ☐Other: _____

Prescription Information

MEDICATION	STRENGTH	*DIRECTIONS	QUANTITY	REFILLS
Yescarta (axicabtagene ciloleucel)				

Clinical Information

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

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

1. Is Yescarta prescribed by or in consultation with an oncologist or hematologist? ☐Yes ☐No
2. Is disease one of the following? ☐Yes **Mark all that apply** ☐No
   - ☐Diffuse large B-cell lymphoma (DLBCL)
   - ☐Primary mediastinal large B-cell lymphoma (PMBCL)
   - ☐Transformed follicular lymphoma (TFL) to DLBCL
   - ☐Transformed nodal marginalized lymphoma (MZL) to DLBCL
   - ☐High-grade B-cell lymphoma
   - ☐Monomorphic post-transplant lymphoproliferative disorders (B-cell type)
   - ☐Follicular lymphoma grade 1, 2, or 3a (FL)

   a. *If high grade B-cell lymphoma*, do any of the following apply? ☐Yes **Mark all that apply** ☐No
      - ☐Transformations of MYC and BCL2
      - ☐Transformations of BCL6 (double/triple hit lymphoma)
      - ☐Not otherwise specified:

      _____
3. Is disease refractory? ☐Yes ☐No
4. Does patient have history of or current central nervous system (CNS) disease? ☐Yes ☐No
5. Has patient previously received treatment with CAR T-cell immunotherapy (e.g. Kymriah, Brevanzi)? ☐Yes ☐No
6. Is Yescarta prescribed concurrently with other CAR T-cell immunotherapy (e.g. Kymriah, Brevanzi)? ☐Yes ☐No
7. **If large B cell lymphoma**, has patient relapsed after ≥ 2 lines of systemic therapy that includes Rituxan (rituximab) and one anthracycline- containing regimen (e.g., doxorubicin)? ☐Yes: _____ ☐No
8. Please document patient's recent (within 30 days) absolute lymphocyte count (ALC): _____/μL; date of testing: _____
9. **If follicular lymphoma,** has patient relapsed after ≥ 2 lines of systemic therapy that includes a combination of an anti-CD20 monoclonal antibody (e.g. Rituxan or Gazyva) and an alkylating agent (e.g. bendamustine, cyclophosphamide, cholorambucil)? ☐Yes: _____ ☐No

Please continue to page 2.

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Patient Name: _____ **DOB:** _____

Complete this section ONLY for indications other than large B-cell lymphoma or follicular lymphoma:

10. 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 COMPLETED BY THE HEALTH PLAN / CPS 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 [**CP.PHAR.362 Axicabtagene Ciloleucel (Yescarta)**]
Date Policy last reviewed/approved by plan (we want to be sure we are using the version approved by your plan):
_____

☐ State or Health Plan Specific (please include policy) _____

☐ Medicare Local Coverage Decision (LCD) specific for your region.
Please include policy of link to LCD, followed by any applicable step therapy requirements. _____

☐ Medicare National Coverage Decision (NCD).
Please include policy of link to NCD, followed by any applicable step therapy requirements. _____