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:	

Primary Diagnosis

ICD-10 Code: _____

☐ Mantle Cell Lymphoma ☐ Other: _____

Prescription Information

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
Tecartus (brexucabtagene autoleucel)				

Clinical Information

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

☐ **INITIAL THERAPY** ☐ **CONTINUATION OF THERAPY;** Therapy start date: _____

1. Please document patient's weight: _____ kg
2. Is Tecartus prescribed by or in consultation with an oncologist or hematologist? ☐ Yes ☐ No
3. Is disease relapsed or refractory? ☐ Yes ☐ No
4. Is member's most recent absolute lymphocyte count ≥ 100 cells/µL? ☐ Yes: _____ cells/µL Date: _____ ☐ No
5. Does patient have history of active, primary, or secondary central nervous system (CNS) disease (e.g., CNS lymphoma, seizure disorder)?
   ☐ Yes (please specify): _____ ☐ No
6. Has patient previously received 2 to 5 prior regimens that included all of the following?
   ☐ Yes **Mark all that apply** ☐ No ☐ Contraindicated/intolerant
   ☐ 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: _____
7. Does member have a history of allogeneic stem cell transplantation? ☐ Yes ☐ No
8. Has patient previously been treated with CAR T-cell immunotherapy (e.g. Kymriah, Yescarta)? ☐ Yes (please specify): _____ ☐ No
9. Will Tecartus be prescribed concurrently with other CAR T-cell immunotherapy (e.g. Kyrmiah, Yescarta)? ☐ Yes ☐ No

Complete this section ONLY for indications <u>other</u> than mantle cell 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

Please continue to page 2.

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Patient Name: _____ **DOB:** _____

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 (CY2019/20 Carved out)	**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 only criteria for CY2019 and CY2020: Carved out to FFS (Fee for service) Medicare