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

**Please continue to page 2.**

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**Patient Name:** _____ **DOB:** _____

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: _____
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 COMPLETED BY THE HEALTH PLAN / CPS PA STAFF

**Authorization Information**

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

***Criteria:**

☐ Centene Policy [**CP.PHAR.472 Brexucabtagene autoleucel (Tecartus)**]
Date Policy last reviewed/approved by plan (we want to be sure we are using the version approved by your plan): _____

☐ State of Health Plan Specific (<u>please include policy</u>) _____

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

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