peach state health plan

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

Brexucabtagene autoleucel (Tecartus)

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:	

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* *****

* **THERAPY TYPE (choose one):** ☐ 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, secondary central nervous system (CNS) disease or CNS disorders as detected by magnetic resonance imaging (MRI)? ☐ 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: ____
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. Breyanzi, Kymriah, Yescarta)?
   ☐ Yes (please specify):___________ ☐ No
9. Will Tecartus be prescribed concurrently with other CAR T-cell immunotherapy (e.g. Breyanzi, Kyrmiah, Yescarta)? ☐ Yes ☐ No

Please continue to page 2.

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Patient Name: ______________________________ **DOB:** ______________

Complete this section ONLY for indications other 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

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)