



# Obecabtagene autoleucl (Aucatzyl)

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

## Prior Authorization Form/Prescription

Date: \_\_\_\_\_ Date Medication Required: \_\_\_\_\_  
Ship to:  Physician  Patient's Home  Other \_\_\_\_\_

The information below can be completed by the Health Plan and/or Centene Pharmacy Services (CPS) staff

### Patient Information

*Last Name:	*First Name:	Middle:	*DOB: / /
Daytime Phone:		Evening Phone:	*Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female

### Insurance Information

*Primary Insurance (Health Plan Name and State)	*ID #:
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### Physician Information

*Name:	*Specialty:	*Phone #:
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### Procedural Hospital

*Hospital Name:
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### Primary Diagnosis

*ICD-10 Code:
<input type="checkbox"/> B-cell precursor acute lymphoblastic leukemia (ALL) <input type="checkbox"/> Other: _____

### Prescription Information

MEDICATION	STRENGTH	*DIRECTIONS	QUANTITY	REFILLS
Aucatzyl (Obecabtagene autoleucl)				

### Clinical Information

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

\* THERAPY Start Date: \_\_\_\_\_

- Is Aucatzyl prescribed by or in consultation with an oncologist or hematologist?  Yes  No
- Is disease relapsed or refractory?  Yes **\*\*Mark all that apply\*\***  No
  - Primary refractory disease  Relapsed or refractory disease after 2 or more lines of systemic therapy
  - First relapse if first remission ≤ 12 months  Relapsed or refractory disease following allogeneic stem cell transplantation
  - a. *If relapsed or refractory disease following allogeneic stem cell transplantation, provide date of transplant:* \_\_\_\_\_
- Is disease Philadelphia chromosome positive (Ph+)?  Yes  No
- Has patient failed 2 tyrosine kinase inhibitors?  Yes **\*\*Mark all that apply\*\***  No
  - Imatinib  Sprycel  Tassigna  Bosulif  Iclusig  Other: \_\_\_\_\_
- Has patient failed 1 second-generation tyrosine kinase inhibitor?  Yes **\*\*Mark all that apply\*\***  No
  - Bosulif  Sprycel  Tassigna  Other: \_\_\_\_\_
- Does patient have contraindication to all tyrosine kinase inhibitors?  Yes  No
- Has patient previously received Blincyto treatment?  Yes  No
  - a. *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
- Does patient have central nervous system (CNS)-3 disease, defined as detectable cerebrospinal blast cells in a sample of CSF with ≥ 5 WBCs/mm<sup>3</sup>, or history of or presence of any CNS disorder?
  - Yes **\*\*Mark all that apply\*\***  No
  - Seizure disorder  Cerebellar disease  Cerebrovascular ischemia/hemorrhage
  - Dementia  Cerebral edema  Posterior reversible encephalopathy syndrome
  - Autoimmune disease with CNS involvement  Other: \_\_\_\_\_
- Does patient have CNS-2 disease, defined as cerebrospinal fluid (CSF) blast cells with < 5 WBCs/mm<sup>3</sup>?  Yes  No
  - a. *If yes, is there documentation of no clinically evident neurological changes?*  Yes  No
- Has patient previously received treatment with CAR T-cell immunotherapy?  Yes **\*\*Mark all that apply\*\***  No
  - Abecma  Breyanzi  Carvykti  Kymriah  Tecartus  Yescarta  Other: \_\_\_\_\_
- Is Aucatzyl prescribed concurrently with other CAR T-cell immunotherapy?  Yes **\*\*Mark all that apply\*\***  No
  - Abecma  Breyanzi  Carvykti  Kymriah  Tecartus  Yescarta  Other: \_\_\_\_\_

### Complete this section ONLY for indications other than ALL:

12. Has patient tried and failed, or is contraindicated to, accepted standards of care?  Yes  No

**\*\*If yes, submit documentation and answer the following:\*\***

- Please list all previous therapies: \_\_\_\_\_
- Was patient adherent to previously tried therapies?  Yes  No  No, patient intolerant to drug



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**Please continue to page 2.**

**Patient Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

### Information

<b>*Number:</b>	<b>*Date of Request:</b>
<b>*HCPCS Code:</b>	<b>*Decision Due Date:</b>
<b>* Line of Business:</b> <input type="checkbox"/> Commercial <input type="checkbox"/> Health Insurance Marketplace <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare	<b>* Benefit:</b> <input type="checkbox"/> Medical <input type="checkbox"/> Pharmacy

**\* Choose one criteria option below based on line of business:**

**Medicare Criteria Only:**

- Medicare Local Coverage Decision (LCD) specific for your region  
Please include policy of link to LCD, followed by any applicable Medicare Part B step therapy requirements in MCPB.ST.00.
- Medicare National Coverage Decision (NCD).  
Please include policy of link to NCD, followed by any applicable Medicare Part B step therapy requirements in MCPB.ST.00.

**Medicaid, Commercial, Exchange (Ambetter) Criteria:**

- Centene Policy [CP.PHAR.675 Obecabtagene Autoleucel (Aucatzyl)]  
Date Policy last reviewed/approved by plan (we want to be sure we are using the version approved by your plan):  
\_\_\_\_\_

**OR**

- State or Health Plan Specific (please include policy)