peach state health plan

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

Lisocabtagene maraleucel (Breyanzi)
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:	

Procedural Hospital

*Hospital Name:

Primary Diagnosis

*ICD-10 Code: _____

☐Diffuse large B-cell lymphoma (DLBCL) ☐Primary mediastinal Large B-Cell Lymphoma (PMBCL)
☐Transformed follicular Lymphoma (TFL) to DLBCL ☐Transformed nodal marginal zone Lymphoma (MZL) to DLBCL
☐Transformed gastric mucosa-associated lymphoid tissue (MALT) lymphoma to DLBCL ☐AIDS-related diffuse large B-cell lymphoma
☐AIDS-related primary effusion lymphoma ☐HHV8-positive diffuse large B-cell lymphoma ☐Follicular lymphoma grade 3B
☐Transformed nongastric MALT lymphoma (noncutaneous) to DLBCL ☐Transformed splenic marginalized zone lymphoma to DLBCL
☐High-grade B-cell lymphoma: _____ ☐Monomorphic post-transplant lymphoproliferative disorders (B-cell type)
☐T cell/histiocyte-rich LBCL ☐Other: _____

Prescription Information

MEDICATION	STRENGTH	*DIRECTIONS	QUANTITY	REFILLS
Breyanzi (lisocabtagene maraleucel)				

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 Breyanzi prescribed by or in consultation with an oncologist or hematologist? ☐Yes ☐No
3. Is disease relapsed or refractory? ☐Yes ☐No
4. Does patient have primary central nervous system (CNS) disease? ☐Yes ☐No
5. Is request for second line therapy? ☐Yes ☐No
6. Has patient previously received ≥ 2 prior systemic therapies that included both of the following? ☐Yes **Mark all that apply** ☐No
   ☐Anthracycline-containing regimen (e.g., doxorubicin): _____
   ☐Anti-CD20 monoclonal antibody therapy (e.g., rituximab): _____
7. Has patient previously been treated with CAR T-cell immunotherapy? ☐Yes **Mark all that apply** ☐No
   ☐Abecma ☐Carvykti ☐Kymriah ☐Tecartus ☐Yescarta ☐Other: _____
8. Is Breyanzi prescribed concurrently with other CAR T-cell immunotherapy (e.g. Kymriah, Yescarta)? ☐Yes ☐No
9. **If High-grade B-cell lymphoma**, do any of the following apply to patient's disease? ☐Yes **Mark all that apply** ☐No
   ☐Translocations of MYC and BCL2 ☐Translocations of MYC and BCL6 ☐Translocations of MYC and BCL2 and BCL6
   ☐Other: _____

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Patient Name: _____ **DOB:** _____

Complete this section ONLY for indications <u>other</u> than those listed above:

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.483 (Lisocabtagene Maraleucel (Breyanzi)**]
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 (<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).
<u>Please include policy of link to NCD, followed by any applicable step therapy requirements.</u> _____