peach state health plan

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

Axicabtagene ciloleucel (Yescarta)
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: _____
☐ Large B-cell lymphoma (LBCL) ☐ Other: _____

Prescription Information

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
Yescarta (axicabtagene ciloleucel)				

Clinical Information

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

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

1. Is Yescarta prescribed by or in consultation with an oncologist or hematologist? ☐ Yes ☐ No
2. Is disease refractory? ☐ Yes ☐ No
3. Has patient relapsed after ≥ 2 lines of systemic therapy that includes Rituxan (rituximab) and one anthracycline containing regimen (e.g., doxorubicin)? ☐ Yes: _____ ☐ No
4. Please document patient's absolute lymphocyte count (ALC): _____/µL; date of testing: _____
5. Does patient have active or primary central nervous system (CNS) disease? ☐ Yes ☐ No

Complete this section ONLY for indications <u>other</u> than large B-cell lymphoma:

6. 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)
Medicare only criteria for CY2019 and CY2020: Carved out to FFS (Fee for service) Medicare