peach state health plan

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

Tisagenlecleucel (Kymriah)
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: _____

☐B-cell precursor acute lymphoblastic leukemia (ALL) ☐Large B-cell lymphoma (LBCL) ☐Other: _____

Prescription Information

MEDICATION	STRENGTH	*DIRECTIONS	QUANTITY	REFILLS
Kymriah (tisagenlecleucel)				

Clinical Information

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

***THERAPY TYPE (choose one):** ☐INITIAL THERAPY ☐CONTINUATION OF THERAPY - Therapy start date: _____

1. Is Kymriah prescribed by or in consultation with an oncologist or hematologist? ☐Yes ☐No
2. Does disease have CD19 tumor expression? ☐Yes ☐No
3. Is disease refractory? ☐Yes ☐No
4. Please document the following (within the last 30 days): ***Attach laboratory results***
   a. Absolute lymphocyte count (ALC): _____ /µL; date: _____
   b. CD3 (T-cells) cell count: _____ /µL; date: _____
   c. CAR-positive viable T cells: _____ x 10^8
5. Has patient relapsed after ≥ 2 lines of systemic therapy? ☐Yes ☐No
6. **If acute lymphoblastic lymphoma**,
   a. Is disease Philadelphia chromosome positive? ☐Yes ☐No
      i. *If yes*, has patient failed 2 tyrosine kinase inhibitors (e.g. imatinib, dasatinib, nilotinib, bosutinib, ponatinib) at maximally indicated doses? ☐Yes ☐No ☐Contraindicated/intolerant
   b. Has patient relapsed following hematopoietic stem cell transplantation (HSCT)? ☐Yes ☐No
      i. *If yes,* will Kymriah be infused ≥ 6 months from date of HSCT? ☐Yes ☐No
   c. How much does patient weigh? _____ kg
7. **If large B-cell lymphoma**,
   a. Is disease one of the following? ☐Yes ***Mark all that apply*** ☐No
      ☐Diffuse large B-cell lymphoma (DLBCL)
      ☐Primary mediastinal large B-cell lymphoma (PMBCL)
      ☐Transformed follicular lymphoma (TFL) to DLBCL
      ☐Transformed nodal marginalized lymphoma (MZL) to DLBCL
      ☐High-grade B-cell lymphoma
      ☐Monomorphic post-transplant lymphoproliferative disorders (B-cell type)

Please continue to page 2.

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Patient Name: _____ **DOB:** _____

i. *If high grade B-cell lymphoma*, do any of the following apply? ☐Yes ***Mark all that apply*** ☐No

☐Transformations of MYC and BCL2 ☐Transformations of BCL6 (double/triple hit lymphoma)
☐Not otherwise specified: _____

b. Does patient have active or primary central nervous system (CNS) disease? ☐Yes, active ☐Yes, primary ☐No
c. Has patient's previously therapy included Rituxan and an anthracycline-containing regimen (e.g., doxorubicin)? ☐Yes ☐No

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

8. 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.361 Tisagenlecleucel (Kymriah)**]
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)
<u>Please include policy of link to NCD, followed by any applicable step therapy requirements.</u> _____