

Yescarta® (Axicabtagene Ciloleucel) Prior Authorization Form

Member Name: _____ Date of Birth: _____ Member ID#: _____

Drug Information

Physician billing (HCPCS code: _____) Start Date: _____

Billing Provider Information

SoonerCare Provider ID: _____ Provider Name: _____

Provider Phone: _____ Provider Fax: _____

Prescriber Information

Prescriber NPI: _____ Prescriber Name: _____

Prescriber Phone: _____ Prescriber Fax: _____ Specialty: _____

Criteria

For Authorization:

1. Please include the most recent office visit note or clinical summary from the hospital to support your request.
Is this information attached? Yes ___ No ___
2. Is the health care facility on the certified list to administer CAR T-cells? Yes ___ No ___
3. Is the health care facility trained in the management of cytokine release syndrome (CRS) and neurologic toxicities? Yes ___ No ___
4. Will the health care facility comply with the Yescarta® REMS Program requirements? Yes ___ No ___
5. Please indicate the diagnosis and information:

Large B-cell lymphoma

- A. Does diagnosis include diffuse large B-cell lymphoma (DLBCL), high grade B-cell lymphoma, DLBCL arising from follicular lymphoma (FL), or FL? Yes ___ No ___
- B. If diagnosis includes DLBCL, high grade B-cell lymphoma, or DLBCL arising from FL, does member have primary central nervous system lymphoma? Yes ___ No ___
- C. Is disease status refractory or relapsed? Yes ___ No ___
 - i. If refractory or relapsed disease, has member received 2 or more lines of therapy? Yes ___ No ___
 1. If yes, please provide additional information regarding previous therapies member has tried and failed: _____
 - ii. If refractory or relapsed disease, has member received 1 previous line therapy? Yes ___ No ___
 1. Is disease refractory to first-line chemotherapy? Yes ___ No ___
 2. Did relapse occur within 12 months of first-line chemotherapy? Yes ___ No ___

If diagnosis is not listed above, please indicate diagnosis: _____

Additional Information: _____

Prescriber Signature: _____ **Date:** _____

I certify that the indicated treatment is medically necessary and all information is true and correct to the best of my knowledge.

Failure to complete this form in full and attach requested clinical notes will result in processing delays.

<p>Fax completed prior authorization request form to 888-601-8461 or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts. All requested data must be provided. Incomplete forms or forms without the chart notes will be returned. Pharmacy Coverage Guidelines are available at AetnaBetterHealth.com/Oklahoma.</p>	<p>CONFIDENTIALITY NOTICE</p> <p><i>This document, including any attachments, contains information which is confidential or privileged. If you are not the intended recipient, be aware that any disclosure, copying, distribution, or use of the contents of this information is prohibited. If you have received this document in error, please notify the sender immediately by telephone to arrange for the return of the transmitted documents or to verify their destruction.</i></p>
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