

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

Drug Information

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

Billing Provider Information

Provider NPI: _____ 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 Kymriah® REMS Program requirements? Yes ___ No ___
5. Please indicate the diagnosis and information:
 - Acute Lymphoblastic Leukemia (ALL)**
 - A. Is diagnosis B-Cell precursor ALL? Yes ___ No ___
 - B. Is diagnosis Philadelphia chromosome negative (Ph-) ALL? Yes ___ No ___
 - C. Is diagnosis Philadelphia chromosome positive (Ph+) ALL? Yes ___ No ___
 - i. If Ph+ ALL, has member failed two or more Tyrosine Kinase Inhibitors (TKIs)?
Yes ___ No ___
 - ii. Please list previously failed TKIs: _____
 - D. Is ALL refractory or relapsed? Yes ___ No ___
 - i. If relapsed, please specify number of relapses: _____Please provide additional information regarding previous therapies member has tried and failed:

 - Large B-cell lymphoma**
 - A. Is diagnosis Diffuse large B-cell lymphoma (DLBCL) not otherwise specified, primary mediastinal large B-cell lymphoma, high grade B-cell lymphoma, or DLBCL arising from follicular lymphoma)? Yes ___ No ___
 - B. Does member have primary central nervous system lymphoma? Yes ___ No ___
 - C. Is disease status refractory or relapsed after 2 or more lines of therapy? Yes ___ No ___
 - D. Please provide additional information regarding previous therapies member has tried and failed:

 - If answer is none of the above, please indicate diagnosis: _____

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. Please do not send in chart notes. Specific information will be requested if necessary. Failure to complete this form in full and attach requested clinical notes will result in processing delays.

PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:

University of Oklahoma College of Pharmacy
Pharmacy Management Consultants
Product Based Prior Authorization Unit

Fax: 1-800-224-4014
Phone: 1-800-522-0114 Option 4

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