SoonerCare
Oklahoma Health Care Authority

State of Oklahoma
Oklahoma Health Care Authority
Kymriah™ (Tisagenlecleucel) 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 healthcare facility on the certified list to administer CAR T cells? Yes ___ No___
3. Is the healthcare facility trained in the management of cytokine release syndrome (CRS) and neurologic toxicities? Yes ___ No___
4. Are both prescriber and patient enrolled in the Kymriah™ REMS Program? 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: _____
F. Please provide additional information regarding previous therapies member has tried and failed:
_____
_____

☐ If answer is none of the 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.

PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:	CONFIDENTIALITY NOTICE
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	*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.*