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

***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 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: _____
E. Please provide additional information regarding previous therapies member has tried and failed:
_____
_____

☐ Lymphoma

A. Please provide specific lymphoma diagnosis:_____
B. Is disease relapsed or refractory? Yes ☐ No☐
C. Has the member failed 2 or more lines of therapy? Yes ☐ No☐
   i. If yes, please list 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: | CONFIDENTIALITY NOTICE |
|---|---|
| University of Oklahoma College of Pharmacy<br>Pharmacy Management Consultants<br>Product Based Prior Authorization Unit<br><br>Fax: 1-800-224-4014<br>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.* |



OHCA Approved – 05/25/2018