

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. 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: _____

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>PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:</p> <p>University of Oklahoma College of Pharmacy Pharmacy Management Consultants Product Based Prior Authorization Unit</p> <p>Fax: 1-800-224-4014 Phone: 1-800-522-0114 Option 4</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>
--	--