PriorityHealth

Pharmacy Prior Authorization Form

Fax completed form to: 877.974.4411 toll free, or 616.942.8206

This form applies to: ☒ **Commercial (Traditional)** ☐ **Commercial Individual (Optimized)** ☐ **Medicaid**

This request is: ☐ **Urgent** (life threatening) ☐ **Non-Urgent** (standard review)

Urgent means the standard review time may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.

Yescarta™ (axicabtagene ciloleucel)

Member

Last Name: _____ First Name: _____

ID #: _____ DOB: _____ Gender: _____

Primary Care Physician: _____

Requesting Physician: _____ Phys. Phone: _____ Phys. Fax: _____

Physician Address: _____

Physician NPI: _____ Contact Name: _____

Provider Signature: _____ Date: _____

Product Information

Drug product: ☐ Yescarta intravenous suspension **Dose:**_____ **Dose Frequency**:_____

Start date (or date of next dose): _____

Date of last dose (if applicable): _____

Date of next dose: _____

Place of administration:
☐ Physician's office
☐ Outpatient infusion
Facility: _____ NPI:_____ Fax:_____
☐ Home infusion
Facility: _____ NPI:_____ Fax:_____

Billing:
☐ Physician to buy and bill
☐ Facility to buy and bill
☐ Specialty Pharmacy
Pharmacy:_____ NPI:_____ Fax:_____

ICD-10 Diagnosis code(s): _____

Drug cost information

The wholesale acquisition cost for one dose of Yescarta™ is $373,000.

Precertification Requirements

Before this drug is covered, documentation must be submitted to support that the patient meets all of the following requirements:

1. Diagnosis of:
   a. Diffuse Large B-cell Lymphoma (DLBCL) unspecified or from follicular lymphoma
   b. Primary mediastinal large B-cell lymphoma
   c. High grade B-cell lymphoma

All fields must be complete and legible for review. Your office will receive a response via fax.

New 12/2017
Last updated 12/2017
Last reviewed 01/2019

2. Must have previously used two or more lines of systemic therapy
3. Patient has or will receive lymphodepleting chemotherapy with fludarabine and cyclophosphamide intravenously on the fifth, fourth, and third day prior to Yescarta infusion

NOTE: Coverage of Yescarta is limited to the dosing listed in the FDA-approved label. Patients greater than 50 kg will be allowed no more than 2.5×10^8 CAR-positive viable T cells. Patients weighting 50 kg or less will be authorized for weight-based dosing of $0.2 – 5 \times 10^6$ CAR-positive viable T cells.

Note: Authorization for indications, dosing, or a route of administration not approved by the Food and Drug Administration (FDA) or recognized in CMS-accepted compendia (e.g. DrugDex, AHFS, U.S. Pharmacopeia, and also Clinical Pharmacology for oncology indications only) require supporting evidence for coverage. Please provide two published peer-reviewed literature articles supporting the appropriateness of the drug, the dosing of the drug, or the route of administration to be used for the identified indication.

Priority Health Precertification Documentation

A. What condition is this drug being requested for?

- ☐ *Diffuse Large B-cell Lymphoma (DLBCL) unspecified or from follicular lymphoma*
- ☐ *Primary mediastinal large B-cell lymphoma*
- ☐ *High grade B-cell lymphoma*
- ☐ *Other – the patient's condition is:* _____

Rationale for use: _____

B. Has the patient tried two or lines of systemic therapy?

☐ Yes

Drug	Dose	Dates	Outcome

☐ No; rationale for use: _____

C. Will the patient receive lymphodepleting chemotherapy with IV fludarabine and cyclophosphamide?

- ☐ Yes (please submit documentation if already completed or treatment plan(s) if not)
- ☐ No; Rationale for use: _____

Additional information

Note: Prior to approving coverage of Yescarta™, a member's plan documents must include coverage for gene therapies with the applicable rider.

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