Trillium Community Health Plan

Tisagenlecleucel (Kymriah)
Prior Authorization Form/Prescription

PLEASE COMPLETE ALL SECTIONS FOR A TIMELY REVIEW

Date: _____ Date Medication Required: _____
Ship to: ❍ Physician ❍ Patient's Home ❍ Other: _____

Patient Information

Last Name:	First Name:	Middle:	DOB: ____/____/_____
Address:	City:	State:	Zip:
Daytime Phone:	Evening Phone:	Sex: ☐ Male ☐ Female	

Insurance Information (*Attach copies of cards*)

Primary Insurance:		Secondary Insurance:	
ID #	Group #	ID #	Group #
City:	State:	City:	State:

Physician Information

Name:	Specialty:	NPI:	
Address:	City:	State:	Zip:
Phone #:	Secure Fax #:	Office Contact:	

Primary Diagnosis

ICD-10 Code: _____

☐B-cell precursor acute lymphoblastic leukemia (ALL) ☐Large B-cell lymphoma (LBCL) ☐Other: _____

Prescription Information

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
Kymriah (tisagenlecleucel)				

Clinical Information

***** *Please submit supporting clinical documentation* *****

☐**INITIAL THERAPY** ☐**CONTINUATION OF THERAPY;** Therapy start date: _____

1. Is Kymriah prescribed by or in consultation with an oncologist or hematologist? ☐Yes ☐No
2. Does disease have CD19 tumor expression? ☐Yes ☐No
3. Is disease refractory? ☐Yes ☐No
4. Please document the following (within the last 30 days): ***Attach laboratory results***
   a. Absolute lymphocyte count (ALC): _____ /µL; date: _____
   b. CD3 (T-cells) cell count: _____ /µL; date: _____
   c. CAR-positive viable T cells: _____ x 10^8
5. Does patient have active or primary central nervous system (CNS) disease? ☐Yes ☐No
6. Has patient relapsed after ≥ 2 lines of systemic therapy? ☐Yes ☐No
   a. **If large B-cell lymphoma**, does previous therapy include Rituxan and an anthracycline-containing regimen (e.g., doxorubicin)? ☐Yes ☐No
7. **If acute lymphoblastic lymphoma**,
   a. Is disease Philadelphia chromosome positive? ☐Yes ☐No
      i. *If yes*, has patient failed 2 tyrosine kinase inhibitors (e.g. imatinib, dasatinib, nilotinib, bosutinib, ponatinib) at maximally indicated doses? ☐Yes ☐No ☐Contraindicated/intolerant
   b. How much does patient weigh? _____ kg

Complete this section ONLY for indications <u>other</u> than B-cell precursor acute lymphoblastic leukemia or large B-cell lymphoma:

8. Has patient tried and failed, or is contraindicated to, accepted standards of care? ☐Yes ☐No
   If yes, submit documentation and answer the following:
   a. Please list all previous therapies: _____
   b. Was patient adherent to previously tried therapies? ☐Yes ☐No ☐No, patient intolerant to drug

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Physician's Signature: _____ **Date:** _____ ☐ DAW

INFORMATION BELOW IS TO BE COMPLETE BY THE HEALTH PLAN/ EPS PA STAFF

Authorization Information

Authorization number:	**Decision Due Date:**
J-Code:	**Coverage:** ❑ State excludes ❑ COB (secondary)
Line of Business: ❑ Commercial ❑ Health Insurance Marketplace ❑ Medicaid ❑ Medicare (CY2019/20 Carved out)	**Benefit:** ❑ Medical ❑ Pharmacy

Criteria:

❑ Centene Policy

Date Policy last reviewed/approved by plan (we want to be sure we are using the version approved by your plan): _____

❑ State Specific (please include policy)

Medicare only criteria for CY2019 and CY2020: Carved out to FFS (Fee for service) Medicare