# Kymriah

## Prior Authorization Request

Your patient's benefit plan requires prior authorization for certain medications. In order to make appropriate medical necessity determinations, your patient's diagnosis and other clinical information is required. **Please complete the information requested on the form below and fax this form along with supporting clinical documentation to Priority Partners, toll-free at 1-866-212-4756** to initiate the review process. If you have questions regarding the prior authorization please contact Priority Partners at 888-819-1043 Option 4**.**

**Patient's Name:** _____ **Date**: _____
**Patient's ID:** _____ **Patient's Date of Birth:** _____
**Physician's Name:** _____
**Specialty:** _____ **NPI#:** _____
**Physician Office Telephone:** _____ **Physician Office Fax:** _____

**Referring Provider Info:** ❑ **Same as Requesting Provider**
**Name:** _____ **NPI#:** _____
**Fax:** _____ **Phone:** _____

**Rendering Provider Info:** ❑ **Same as Referring Provider** ❑ **Same as Requesting Provider**
**Name:** _____ **NPI#:** _____
**Fax:** _____ **Phone:** _____

***Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.***

**Required Demographic Information:**

*Patient Weight:* _____*kg*

*Patient Height:*_____*cm*

*Please indicate the place of service for the requested drug:*

❑ *Ambulatory Surgical* ❑ *Home* ❑ *Off Campus Outpatient Hospital*
❑ *On Campus Outpatient Hospital* ❑ *Office*

**Drug Information:**

*Strength/Measure*_____ *Units* ❑ ml ❑ Gm ❑ mg ❑ ea ❑ Un
*Directions(sig)*_____ *Route of administration*_____
*Dosing frequency*_____

**Send completed form to: Priority Partners Fax: 1-866-212-4756**

**Criteria Questions:**

1. What is the diagnosis?
   - ❑ Acute lymphoblastic leukemia (ALL)
   - ❑ Diffuse large B-cell lymphoma (DLBCL) arising from follicular lymphoma (also known as histologic transformation of follicular lymphoma to DLBCL)
   - ❑ Histologic transformation of nodal marginal zone lymphoma to DLBCL
   - ❑ Diffuse large B-cell lymphoma
   - ❑ Primary mediastinal large B-cell lymphoma
   - ❑ High-grade B-cell lymphoma (including high-grade B-cell lymphoma with translocations of MYC and BCL2 and/or BCL6 [double/triple hit lymphoma], high-grade B-cell lymphoma, not otherwise specified)
   - ❑ Acquired immunodeficiency syndrome (AIDS)-related B-cell lymphomas (including AIDS-related diffuse large B-cell lymphoma, primary effusion lymphoma, and human herpesvirus 8 (HHV8)-positive diffuse large B-cell lymphoma, not otherwise specific)
   - ❑ Monomorphic post-transplant lymphoproliferative disorder (B-cell type)
   - ❑ Other _____

2. What is the ICD-10 code? _____

3. Has the patient previously received one complete treatment course of Kymriah or another CD19-directed chimeric antigen receptor (CAR) T-cell therapy (e.g., Yescarta)? ❑ Yes ❑ No

4. Does the patient have CD19 positive disease that was confirmed by testing or analysis?
   ***ACTION REQUIRED: If Yes, attach results of testing or analysis confirming CD19 protein on the surface of the B-cell.*** ❑ Yes ❑ No ❑ Unknown

***Complete the following section based on the patient's diagnosis, if applicable.***

Section A: Acute Lymphoblastic Leukemia (ALL)

5. Does the patient have B-cell precursor acute lymphoblastic leukemia? ❑ Yes ❑ No

6. Does the patient have relapsed or refractory disease?
   ❑ Yes, relapsed disease ❑ Yes, refractory disease ❑ No

7. What is the Philadelphia chromosome status for the patient's disease?
   - ❑ Philadelphia chromosome-positive disease
   - ❑ Philadelphia chromosome-negative disease, *no further questions*
   - ❑ Unknown

8. Has the patient had an inadequate response to two tyrosine kinase inhibitors (e.g., bosutinib (Bosulif®), dasatinib (Sprycel®), imatinib (Gleevec®), nilotinib (Tasigna®), ponatinib (Iclusig®)?
   *If Yes, no further questions* ❑ Yes ❑ No

9. Has the patient had an intolerance to a tyrosine kinase inhibitor (e.g., bosutinib (Bosulif®), dasatinib (Sprycel®), imatinib (Gleevec®), nilotinib (Tasigna®), ponatinib (Iclusig®)? ❑ Yes ❑ No *If No, no further questions*

10. Has the patient experienced a first relapse post-hematopoietic stem cell transplant? ❑ Yes ❑ No

Section B: Diffuse Large B-Cell Lymphoma (DLBCL) Arising from Follicular Lymphoma (Also Known as Histologic Transformation of Follicular Lymphoma to DLBCL) and Histologic Transformation of Nodal Marginal Zone Lymphoma to DLBCL

11. How many prior chemoimmunotherapy regimens has the patient received? _____ regimens

12. Did at least one prior chemoimmunotherapy regimen received by the patient include an anthracycline or anthracenedione-based regimen? *If Yes, no further questions*
    - ❑ Yes, anthracycline-based regimen
    - ❑ Yes, anthracenedione-based regimen
    - ❑ No

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13. Are anthracycline and anthracenedione-based regimens contraindicated for the patient? ❑ Yes ❑ No

Section C: All Other B-Cell Lymphoma Subtypes

14. Will Kymriah be used as subsequent treatment for the disease? ❑ Yes ❑ No

15. Does the patient have primary central nervous system lymphoma? ❑ Yes ❑ No

***I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by Priority Partners.***

**X_____**

**Prescriber or Authorized Signature** **Date (mm/dd/yy)**

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