JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE

Yescarta

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?
   - ❑ 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 (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)
   - ❑ Follicular lymphoma
   - ❑ Other _____

2. What is the ICD-10 code? _____

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

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

Section A: 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

4. How many prior chemoimmunotherapy regimens has the patient received? _____regimens

5. Did at least one prior chemoimmunotherapy regimen received by the patient include an anthracycline or anthracenedione-based regimen? *If Yes, skip to Section C*
   ❑ Yes, anthracycline-based regimen ❑ Yes, anthracenedione-based regimen ❑ No

6. Are anthracycline and anthracenedione-based regimens contraindicated for the patient?
   If Yes, skip to Section C ❑ Yes ❑ No

Section B: Follicular Lymphoma

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

8. Has the patient received at least two or more lines of systemic therapy? *If Yes, go to Section C* ❑ Yes ❑ No

Section C: All Other B-Cell Lymphoma Subtypes and common requirements

9. Will Yescarta be used as subsequent treatment for the disease ? ❑ Yes ❑ No

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

11. 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

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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