ambetter. FROM peach state health plan

Telephone: (800) 514-0083 option 2
Fax: (866) 374-1579

Afamitresgene Autoleucel (Tecelra)
PDAC Drug Review Form

The information below can be completed by the Health Plan and/or Centene Pharmacy Services (CPS) staff

Patient Information

*Last Name:	*First Name:	Middle:	*DOB: / /
Daytime Phone:	Evening Phone:	*Sex: ☐ Male ☐ Female	

Insurance Information

*Primary Insurance (Health Plan Name and State)	*ID #:

Physician Information

*Name:	*Specialty:	*Phone #:

Procedural Hospital

*Hospital Name:

Primary Diagnosis

*ICD-10 Code: _____

☐Synovial sarcoma ☐Other: _____

Prescription Information

MEDICATION	STRENGTH	*DIRECTIONS	QUANTITY	REFILLS
Tecelra (Afamitresgene Autoleucel)				

Clinical Information

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

* **THERAPY Start Date**: _____

1. Is therapy prescribed by or in consultation with an oncologist? ☐Yes ☐No
2. Is synovial sarcoma unresectable or metastatic? ☐Yes ☐No
3. Is disease positive for 1 of the following? ☐Yes ***Mark all that apply*** ☐No
   ☐HLA-A*02:01P ☐HLA-A*02:02P ☐HLA-A*02:03P ☐HLA-A*02:06P
4. Is patient heterozygous or homozygous for HLA-A*02:05P? ☐Yes ☐No
5. Is there documentation of MAGE-A4 antigen expression as determined by FDA-approved or cleared companion diagnostic device?
   ☐Yes ☐No
6. Has patient received ≥1 prior systemic chemotherapy? ☐Yes ***Mark all that apply*** ☐No
   ☐Cabozantinib ☐Ifosfamide ☐Regorafenib ☐Gemcitabine + dacarbazine ☐Gemcitabine + docetaxel
   ☐Darcabazine ☐Pazopanib ☐Temozolomide ☐Gemcitabine + pazopanib ☐Gemcitabine + vinorelbine
   ☐Doxorubicin ☐AD (doxorubicin, dacarbazine) ☐Vinorelbine ☐Liposomal doxorubicin
   ☐Epirubicin ☐AIM (doxorubicin, ifosfamide mesna) ☐MAID (mesna, doxorubicin, ifosfamide, dacarbazine)
   ☐Gemcitabine ☐Ifosfamide, eriprubicin, mesna ☐Other: _____
7. Has patient received prior allogenic hematopoietic stem cell transplant? ☐Yes ☐No
8. Has patient received prior gene therapy? ☐Yes ☐No
9. How many Tecelra infusions has patient received? ☐< 1 ☐≥ 1

Complete this section ONLY for indications <u>other</u> than Synovial sarcoma:

10. 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

Information

PDAC updated: 09/08/2025
AMB25-GA-HP-00216

Telephone: (800) 514-0083 option 2
Fax: (866) 374-1579

Afamitresgene Autoleucel (Tecelra)
PDAC Drug Review Form

***Number:**	***Date of Request:**
***HCPCS Code:**	***Decision Due Date:**

Please continue to page 2.

Patient Name: _____ **DOB:** _____

* **Line of Business:**	* **Benefit:**
☐ Commercial ☐ Health Insurance Marketplace ☐ Medicaid ☐ Medicare	☐ Medical ☐ Pharmacy

*** Choose one criteria option below based on line of business:**

Medicare Criteria Only:

☐ Medicare Local Coverage Decision (LCD) specific for your region
Please include policy of link to LCD, followed by any applicable Medicare Part B step therapy requirements in MCPB.ST.00.

☐ Medicare National Coverage Decision (NCD).
Please include policy of link to NCD, followed by any applicable Medicare Part B step therapy requirements in MCPB.ST.00.

Medicaid, Commercial, Exchange (Ambetter) Criteria:

☐ Centene Policy [**CP.PHAR.678 Afamitresgene Autoleucel (Tecelra)**]
Date Policy last reviewed/approved by plan (we want to be sure we are using the version approved by your plan):

_____

OR

☐ State or Health Plan Specific (please include policy)