ambetter. FROM peach state health plan

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

Lisocabtagene maraleucel (Breyanzi)
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: _____

Large B-cell lymphoma: ☐Diffuse large B-cell lymphoma (DLBCL) ☐Primary mediastinal Large B-Cell Lymphoma (PMLBCL)
☐Transformed follicular Lymphoma (TFL) to DLBCL ☐Transformed nodal marginal zone Lymphoma (MZL) to DLBCL
☐Transformed gastric mucosa-associated lymphoid tissue (MALT) lymphoma to DLBCL ☐HIV-related diffuse large B-cell lymphoma
☐Primary effusion lymphoma ☐HHV8-positive diffuse large B-cell lymphoma ☐Follicular lymphoma grade 3B
☐Transformed nongastric MALT lymphoma (noncutaneous) to DLBCL ☐Transformed splenic marginalized zone lymphoma to DLBCL
☐High-grade B-cell lymphoma ☐Post-transplant lymphoproliferative disorders (B-cell type) ☐T cell/histiocyte-rich LBCL
☐Follicular lymphoma (FL) grade 1, 2, or 3a ☐Mantle cell lymphoma (MCL) ☐HIV-related plasmablastic lymphoma
Other: ☐Chronic Lymphocytic Leukemia (CLL) ☐Small Lymphocytic Lymphoma (SLL) ☐Other: _____

Prescription Information

MEDICATION	STRENGTH	*DIRECTIONS	QUANTITY	REFILLS
Breyanzi (lisocabtagene maraleucel)				

Clinical Information

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

* **THERAPY Start Date**: _____

1. Is Breyanzi prescribed by or in consultation with an oncologist or hematologist? ☐Yes ☐No
2. Is disease relapsed or refractory? ☐Yes ***Mark all that apply**** ☐No
   ☐Refractory ☐Refractory no complete remission
   ☐Relapsed ☐Relapsed complete remission followed by biopsy-proven disease relapse
3. Has patient previously received CAR T-cell immunotherapy treatment? ☐Yes ***Mark all that apply**** ☐No
   ☐Abecma ☐Carvykti ☐Kymriah ☐Tecartus ☐Yescarta ☐Other: _____
4. Is Breyanzi prescribed concurrently with other CAR T-cell immunotherapy? ☐Yes ***Mark all that apply**** ☐No
   ☐Abecma ☐Carvykti ☐Kymriah ☐Tecartus ☐Yescarta ☐Other: _____
5. **If large B-cell lymphoma**,
   a. Does patient have primary central nervous system (CNS) disease? ☐Yes ☐No
   b. Is patient ineligible for hematopoietic stem cell transplantation (HSCT) due to comorbidities or age?
      ☐Yes: _____
      ☐No
   c. Has patient relapsed after ≥ 2 lines of systemic therapy that included both of the following?
      ☐Yes **Mark all that apply** ☐No
      ☐Anthracycline-containing regimen (e.g., doxorubicin): _____
      ☐Anti-CD20 monoclonal antibody therapy (e.g., rituximab): _____
   d. Has patient relapsed after 1st-line chemoimmunotherapy that included an anti-CD20 monoclonal antibody and anthracycline-containing regimen? ☐Yes ***Mark all that apply**** ☐No
      ☐Rituximab ☐Doxorubicin ☐Other: _____
      i. *If yes*, how many months after 1st-line chemoimmunotherapy did patient relapse? ☐< 12 months ☐≥ 12 months

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AMB25-GA-HP-00216

6. **If CLL or SLL,**
   a. Has patient had any measurable disease within the last 30 days as indicated by one of the following?
   ☐Yes ***Mark all that apply**** ☐No
   ☐Measurable lymph nodes ≥1.5 cm in the greatest transverse diameter ☐Hepatomegaly ☐Splenomegaly
   ☐Demonstration of CLL cells in the peripheral blood by flow cytometry

Please continue to page 2.

Patient Name: _____ **DOB:** _____

   b. Has patient received ≥ 2 prior lines of therapy including one Bruton tyrosine kinase inhibitor (BTKi) and B-cell lymphoma 2 inhibitor (BCL2i)? ☐Yes ***Mark all that apply**** ☐No
   ☐Brukinsa (zanubrutinib) ☐Calquence (acalabrutinib) ☐Campath (alemtuzumab) ☐Copiktra (duvelisib)
   ☐Gazyva (obinutuzumab) ☐Imbruvica (ibrutinib) ☐Jaypirca (pirtobrutinib) ☐Revlimid (lenalidomide)
   ☐Venclexta (venetoclax) ☐Zydelig (idelalisib) ☐High-dose methylprednisolone
   ☐Calquence (acalabrutinib) + Gazyva (obinutuzumab) ☐Campath (alemtuzumab) + rituximab
   ☐FCR (fludarabine, cyclophosphamide, rituximab) ☐High-dose methylprednisolone + Gazyva (obinutuzumab)
   ☐High-dose methylprednisolone + rituximab ☐Imbruvica (ibrutinib) + Gazyva (obinutuzumab)
   ☐Imbruvica (ibrutinib) + rituximab ☐Imbruvica (ibrutinib) + Venclexta (venetoclax)
   ☐Revlimid (lenalidomide) + rituximab ☐Venclexta (venetoclax) + Gazyva (obinutuzumab)
   ☐Venclexta (venetoclax) + rituximab ☐Zydelig (idelalisib) + rituximab
   ☐Other: _____
   c. Does the patient have active CNS involvement by malignancy or history or presence of clinically relevant CNS pathology?
   ☐Yes ***Mark all that apply**** ☐No
   ☐Epilepsy ☐Aphasia ☐Severe brain injuries ☐Cerebral edema ☐Generalized seizure disorder
   ☐Psychosis ☐Dementia ☐Parkinson's disease ☐Cerebellar disease ☐Stroke with current neurologic sequelae

7. **If FL grade 1, 2, or 3a,**
   a. Has patient relapsed after ≥ 2 lines of systemic therapy that included both of the following?
   ☐Yes **Mark all that apply** ☐No
   ☐Alkylating agent (e.g., bendamustine, cyclophosphamide, chlorambucil): _____
   ☐Anti-CD20 monoclonal antibody therapy (e.g., rituximab, Gazyva): _____
   b. Does patient have CNS involvement by malignancy? ☐Yes ☐No
   c. Does patient have history or presence of clinically relevant CNS pathology? ☐Yes ***Mark all that apply**** ☐No
   ☐Epilepsy ☐Aphasia ☐Severe brain injuries ☐Cerebral edema ☐Generalized seizure disorder
   ☐Psychosis ☐Dementia ☐Parkinson's disease ☐Cerebellar disease ☐Stroke with current neurologic sequelae

8. **If MCL,**
   a. Has patient previously received ≥ 2 prior lines of systemic therapy that included all of the following?
   ☐Yes **Mark all that apply** ☐No
   ☐Alkylating agent (e.g., bendamustine, cyclophosphamide, platinum [carboplatin, cisplatin, or oxaliplatin):
   _____
   ☐BTKi (e.g., Imbruvica, Calquence, Brukinsa, Jaypirca): _____
   ☐Anti-CD20 monoclonal antibody therapy (e.g., rituximab): _____
   d. Does patient have CNS involvement by malignancy? ☐Yes ☐No
   e. Does patient have history or presence of clinically relevant CNS pathology? ☐Yes ***Mark all that apply**** ☐No
   ☐Epilepsy ☐Aphasia ☐Severe brain injuries ☐Cerebral edema ☐Generalized seizure disorder
   ☐Psychosis ☐Dementia ☐Parkinson's disease ☐Cerebellar disease ☐Stroke with current neurologic sequelae

Complete this section ONLY for indications <u>other</u> than indication or those listed above:

9. 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	
***Number:**	***Date of Request:**

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Lisocabtagene maraleucel (Breyanzi)
PDAC Drug Review Form

*HCPCS Code:	*Decision Due Date:
* Line of Business: ☐ Commercial ☐ Health Insurance Marketplace ☐ Medicaid ☐ Medicare	* Benefit: ☐ Medical ☐ Pharmacy

Please continue to page 3.

Patient Name: _____ DOB: _____

*** 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.483 (Lisocabtagene Maraleucel (Breyanzi)**]
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)