ambetter. FROM peach state health plan

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

Remestemcel-L-rknd (Ryoncil)
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: _____

☐Acute Graft Versus Host Disease (GVHD) ☐Other: _____

Prescription Information

MEDICATION	STRENGTH	*DIRECTIONS	QUANTITY	REFILLS
Ryoncil (Remestemcel-L-rknd)				

Clinical Information

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

* **THERAPY Start Date**: _____

If prescribed dose exceeds the FDA maximum recommended dose, please submit supporting practice guidelines/peer-reviewed literature

1. Has patient previously received Ryoncil for acute GVHD for at least 28 days? ☐Yes ☐No
2. How many doses of Ryoncil has patient received? _____ doses
3. For requests to extend Ryoncil therapy beyond 28 days, what type of response has patient had to the prescribed therapy? ***Mark all that apply***
   - ☐Complete response: resolution of acute GVHD in all involved organs
     a. *If complete response*, has GVHD recurred following a complete response? ☐Yes ☐No
   - ☐Partial response: organ improvement of at least 1 stage without worsening of any other organs
   - ☐Mixed response: improvement in at least 1 evaluable organ with worsening in another
   - ☐No response: No change in any organ stage in any organ system and no improvement in organ stage
   - ☐Progression: Deterioration in at least 1 organ system by 1 stage or more with no improvement in any other organ
4. Please provide patient's current body weight: _____ kg

Complete this section ONLY if the patient is initiating therapy OR if the patient is new to this health plan:

5. Is therapy prescribed by or in consultation with an oncologist, hematologist, or bone marrow transplant specialist? ☐Yes ☐No
6. Does the patient have a diagnosis of acute GVHD Grade II to IV* following hematopoietic cell transplantation? ☐Yes ☐No
   **Grade II to IV disease goes beyond skin involvement and additionally involves the liver and/or gastrointestinal tract.*
7. Has patient received ≥ 2 mg/kg per day of prednisone or dose equivalent corticosteroid treatment?
   ☐Yes ***Mark all that apply*** ☐No
   ☐Prednisone: _____ mg/kg ☐Prednisolone: _____ mg/kg
   ☐Methylprednisolone: _____ mg/kg ☐Dexamethasone: _____ mg/kg
   ☐Betamethasone: _____ mg/kg ☐Other: _____ : _____ mg/kg
8. Is disease steroid-refractory as evidenced by any of the following?
   ☐Yes ***Mark all that apply*** ☐No
   ☐Progression of acute GVHD within 3 to 5 days of steroid onset ☐Failure to improve within 5 to 7 days of steroid initiation
   ☐Partial response after >28 days of steroid treatment ☐Other: _____

Complete this section ONLY for indications other than GVHD:

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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

Please continue to page 2.

Patient Name: _____ **DOB:** _____

Information	
***Number:**	***Date of Request:**
***HCPCS Code:**	***Decision Due Date:**
* **Line of Business:** ☐ Commercial ☐ Health Insurance Marketplace ☐ Medicaid ☐ Medicare	* **Benefit:** ☐ 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.474 Remestemcel-L-rknd (Ryoncil)**]
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)