ambetter. FROM peach state health plan

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

Tisagenlecleucel (Kymriah)
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:
☐B-cell precursor acute lymphoblastic leukemia (ALL) ☐Large B-cell lymphoma (LBCL) ☐Follicular lymphoma (FL)
☐Other: _____

Prescription Information

MEDICATION	STRENGTH	*DIRECTIONS	QUANTITY	REFILLS
Kymriah (tisagenlecleucel)				

Clinical Information

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

* **THERAPY Start Date**: _____

1. Is Kymriah prescribed by or in consultation with an oncologist or hematologist? ☐Yes ☐No
2. Is disease relapsed or refractory? ☐Yes ***Mark all that apply**** ☐No
   ☐Relapsed ☐Refractory ☐Refractory failure to achieve a complete response following induction therapy
   a. *If yes and **ALL***,
      i. Is disease refractory with ≥ 2 cycles of standard chemotherapy regimen (primary refractory) or after 1 cycle of standard chemotherapy for relapsed leukemia (chemorefractory)? ☐Yes ☐No
      ii. Has patient had ≥ 2 relapses? ☐Yes ☐No
      iii. Has patient relapsed following allogeneic stem cell transplantation (SCT); SCT date: _____
   b. *If yes and **LBCL or FL***, is disease refractory or relapsed after ≥ 2 lines of systemic therapy?
      ☐Yes ***Mark all that apply**** ☐No
      ☐Rituximab ☐Anthracycline-containing regimen (doxorubicin) ☐Other: _____
      ☐Combination of an anti-CD20 monoclonal antibody (rituximab or Gazyva) and an alkylating agent (bendamustine, cyclophosphamide, chlorambucil): _____
   c. *If yes and **FL***, has patient relapsed following autologous stem cell transplantation (SCT)? ☐Yes ☐No
   d. *If yes and **LBCL***, is disease relapsed more than 12 months after completion of first-line therapy and partial response following second-line therapy? ☐Yes ☐No
3. Please document the following (within the last 30 days):
   a. Absolute lymphocyte count (ALC): _____ /µL; date: _____
   b. CD3 (T-cells) cell count: _____ /µL; date: _____
4. Has patient previously received treatment with CAR T-cell immunotherapy ? ☐Yes ***Mark all that apply**** ☐No
   ☐Abecma ☐Carvykti ☐Breyanzi ☐Tecartus ☐Yescarta ☐Other: _____
5. Is Kymriah prescribed concurrently with other CAR T-cell immunotherapy? ☐Yes ***Mark all that apply**** ☐No
   ☐Abecma ☐Carvykti ☐Breyanzi ☐Tecartus ☐Yescarta ☐Other: _____
6. **If ALL**,
   a. Is there documentation of CD19 tumor expression? ☐Yes ☐No
   b. Is disease Philadelphia chromosome positive? ☐Yes ☐No
   c. Has patient received 2 lines of chemotherapy that included 2 tyrosine kinase? ☐Yes ***Mark all that apply**** ☐No
      ☐Imatinib ☐Sprycel ☐Tasigna ☐Bosulif ☐Iclusig ☐Other: _____

d. How much does patient weigh? _____ kg

Please continue to page 2.

Patient Name: _____ **DOB:** _____

7. **If LBCL**,
   a. Is disease one of the following? ☐Yes ***Mark all that apply*** ☐No
      ☐Diffuse large B-cell lymphoma (DLBCL) ☐Primary mediastinal large B-cell lymphoma (PMBCL)
      ☐Transformed follicular lymphoma (TFL) to DLBCL ☐Transformed nodal marginalized lymphoma (MZL) to DLBCL
      ☐High-grade B-cell lymphoma ☐Monomorphic post-transplant lymphoproliferative disorders (B-cell type)
      ☐HIV-related DLBCL, primary effusion lymphoma, & HHV8-positive DLBCL
      i. *If high grade B-cell lymphoma*, do any of the following apply? ☐Yes ***Mark all that apply*** ☐No
         ☐ MYC and BCL2 rearrangements ☐Not otherwise specified: _____
   b. Does patient have active or primary central nervous system (CNS) disease? ☐Yes, active ☐Yes, primary ☐No
8. **If FL**,
   a. What is patient's FL grade? ☐1 ☐2 ☐3a ☐Other: _____
   b. Does patient have active central nervous system (CNS) involvement by malignancy? ☐Yes ☐No

Complete this section ONLY for indications other than 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:**
***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.361 Tisagenlecleucel (Kymriah)**]

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)