Aucatzyl

CareFirst Prior Authorization Request

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-855-330-1720**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-888-877-0518.** For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

The recipient of this fax may make a request to opt-out of receiving telemarketing fax transmissions from CVS Caremark. There are numerous ways you may opt-out: The recipient may call the toll-free number at 877-265-2711, at any time, 24 hours a day/7 days a week. The recipient may also send an opt-out request via email to do_not_call@cvscaremark.com. An opt out request is only valid if it (1) identifies the number to which the request relates, and (2) if the person/entity making the request does not, subsequent to the request, provide express invitation or permission to CVS Caremark to send facsimile advertisements to such person/entity at that particular number. CVS Caremark is required by law to honor an opt-out request within thirty days of receipt.

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*	❑ *Pharmacy*

What is the ICD-10 code? _____

Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-855-330-1720

CVS Caremark Specialty Pharmacy ● 2211 Sanders Road NBT-6 ● Northbrook, IL 60062
Phone: 1-888-877-0518 ● Fax: 1-855-330-1720 ● www.caremark.com

Criteria Questions:

1. Has the patient received a previous treatment course of Aucatzyl (obecabtagene autoleucel) or another CD19-directed chimeric antigen receptor (CAR) T-cell therapy?
❒ Yes, *Continue to 2*
❒ No, *Continue to 2*

2. What is the patient's age?
_____ years of age, *Continue to 3*

3. Does the patient have an Eastern Cooperative Oncology Group (ECOG) performance status of 0 to 2 (the patient is ambulatory and capable of all self-care but unable to carry out any work activities. Up and about more than 50% of waking hours)?
❒ Yes, *Continue to 4*
❒ No, *Continue to 4*

4. Does the patient have adequate and stable kidney, liver, pulmonary and cardiac function?
❒ Yes, *Continue to 5*
❒ No, *Continue to 5*

5. Does the patient have active hepatitis B, active hepatitis C, or any active uncontrolled infection?
❒ Yes, *Continue to 6*
❒ No, *Continue to 6*

6. Does the patient have an active inflammatory disorder?
❒ Yes, *Continue to 7*
❒ No, *Continue to 7*

7. Does the patient have active graft versus host disease?
❒ Yes, *Continue to 8*
❒ No, *Continue to 8*

8. Does the patient have a history or presence of clinically relevant central nervous system (CNS) pathology such as epilepsy, seizure, paresis, aphasia, stroke, subarachnoid hemorrhage or other CNS bleed, severe brain injuries, dementia, Parkinson's disease, cerebellar disease, organic brain syndrome, or psychosis?
❒ Yes, *Continue to 9*
❒ No, *Continue to 9*

9. What is the diagnosis?
❒ Acute lymphoblastic leukemia (ALL), *Continue to 10*
❒ Other, please specify. _____, *Continue to 10*

10. Has the patient received a previous treatment course with any prior CD19 directed therapy other than blinatumomab (Blincyto)?
❒ Yes, *Continue to 11*
❒ No, *Continue to 11*

11. Does the patient have B-cell precursor acute lymphoblastic leukemia?
❒ Yes, *Continue to 12*
❒ No, *Continue to 12*

12. Does the patient have morphological disease in the bone marrow (greater than or equal to 5% blasts)? ***ACTION REQUIRED***: If Yes, attach results of testing or analysis confirming 5% or greater blasts in the bone marrow.

❒ Yes ***ACTION REQUIRED***: Submit supporting documentation, *Continue to 13*

❒ No, *Continue to 13*

❒ Unknown or testing has not been completed, *Continue to 13*

13. What is the Philadelphia chromosome status for the patient's disease?

❒ Philadelphia chromosome-positive disease, *Continue to 15*

❒ Philadelphia chromosome-negative disease, *Continue to 14*

❒ Unknown, *No Further Questions*

14. Does the patient meet any of the following? ***ACTION REQUIRED***: Attach chart notes, medical record documentation or claims history supporting previous lines of therapy.

❒ Patient has primary refractory disease ***ACTION REQUIRED***: Submit supporting documentation, *No Further Questions*

❒ Patient has had first relapse with remission of 12 months or less ***ACTION REQUIRED***: Submit supporting documentation, *No Further Questions*

❒ Patient has relapsed or refractory disease after at least 2 previous lines of systemic therapy ***ACTION REQUIRED***: Submit supporting documentation, *No Further Questions*

❒ Patient has relapsed or refractory disease after allogeneic stem cell transplant (allo-SCT) ***ACTION REQUIRED***: Submit supporting documentation, *No Further Questions*

❒ None of the above, *No Further Questions*

15. Does the patient meet any of the following? ***ACTION REQUIRED***: Attach chart notes, medical record documentation or claims history supporting previous lines of therapy.

❒ Patient has relapsed or refractory disease despite treatment with at least 2 different tyrosine kinase inhibitors (TKIs) (e.g., bosutinib, dasatinib, imatinib, nilotinib, ponatinib) or one line of second-generation TKI ***ACTION REQUIRED***: Submit supporting documentation, *No Further Questions*

❒ Patient is intolerant to TKI therapy or TKI therapy is contraindicated ***ACTION REQUIRED***: Submit supporting documentation, *No Further Questions*

❒ None of the above, *No Further Questions*

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X_____

Prescriber or Authorized Signature **Date (mm/dd/yy)**

Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-855-330-1720