



## Kymriah

### 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.

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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:

- |  |                                 |   |
|--|---------------------------------|---|
| <input type="checkbox"/> Ambulatory Surgical           | <input type="checkbox"/> Home   | <input type="checkbox"/> Off Campus Outpatient Hospital |
| <input type="checkbox"/> On Campus Outpatient Hospital | <input type="checkbox"/> Office | <input type="checkbox"/> Pharmacy                       |

What is the ICD-10 code? \_\_\_\_\_

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

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**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](http://www.caremark.com)**

**Criteria Questions:**

1. Has the patient previously received a treatment course of Kymriah or another CD19-directed chimeric antigen receptor (CAR) T-cell therapy (e.g., Yescarta)?

☐ Yes, *Continue to 2*

☐ No, *Continue to 2*

2. Does the patient have adequate and stable kidney, liver, pulmonary and cardiac function?

☐ Yes, *Continue to 3*

☐ No, *Continue to 3*

3. Does the patient have active or latent hepatitis B, active hepatitis C, or any active uncontrolled infection?

☐ Yes, *Continue to 4*

☐ No, *Continue to 4*

4. Does the patient have active graft versus host disease?

☐ Yes, *Continue to 5*

☐ No, *Continue to 5*

5. Does the patient have an active inflammatory disorder?

☐ Yes, *Continue to 6*

☐ No, *Continue to 6*

6. What is the diagnosis?

☐ Acute lymphoblastic leukemia (ALL), *Continue to 7*

☐ Diffuse large B-cell lymphoma (DLBCL) arising from follicular lymphoma, *Continue to 15*

☐ Follicular lymphoma (FL), *Continue to 15*

☐ Histologic transformation of indolent lymphomas to DLBCL, *Continue to 15*

☐ Diffuse large B-cell lymphoma, *Continue to 15*

☐ High-grade B-cell lymphoma (including high-grade B-cell lymphoma with translocations of MYC and BCL2 and/or BCL6 [double/triple hit lymphoma], high-grade B-cell lymphoma, not otherwise specified), *Continue to 15*

☐ Human immunodeficiency virus (HIV)-related B-cell lymphomas (including HIV-related diffuse large B-cell lymphoma, primary effusion lymphoma, and human herpesvirus 8 (HHV8)-positive diffuse large B-cell lymphoma, not otherwise specific), *Continue to 15*

☐ Monomorphic post-transplant lymphoproliferative disorder (B-cell type), *Continue to 15*

☐ Other, please specify. \_\_\_\_\_, *No Further Questions*

7. Does the patient have B-cell precursor acute lymphoblastic leukemia?

☐ Yes, *Continue to 8*

☐ No, *Continue to 8*

8. Does the patient have CD19 tumor expression in bone marrow or peripheral blood? **ACTION REQUIRED:** If Yes, attach chart note(s) or test results confirming CD19 tumor expression in bone marrow or peripheral blood.

☐ Yes **ACTION REQUIRED:** *Submit supporting documentation, Continue to 9*

☐ No, *Continue to 9*

☐ Unknown or testing has not been completed, *Continue to 9*

9. Does the patient have at least 5% lymphoblasts in the bone marrow? **ACTION REQUIRED:** If Yes, attach results of testing or analysis confirming at least 5% lymphoblasts in the bone marrow.

☐ Yes **ACTION REQUIRED:** *Submit supporting documentation, Continue to 10*

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- ☐ No, *Continue to 10*
- ☐ Unknown or testing has not been completed, *Continue to 10*

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

- ☐ Philadelphia chromosome-positive disease, *Continue to 11*
- ☐ Philadelphia chromosome-negative disease, *Continue to 12*
- ☐ Unknown, *Continue to 11*

11. 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 refractory disease **ACTION REQUIRED:** *Submit supporting documentation, Continue to 13*
- ☐ Patient has had 2 or more relapses and has failed at least 2 tyrosine kinase inhibitors (TKIs) (e.g., bosutinib, dasatinib, imatinib, nilotinib, ponatinib) **ACTION REQUIRED:** *Submit supporting documentation, Continue to 13*
- ☐ Patient has relapsed disease and is TKI intolerant **ACTION REQUIRED:** *Submit supporting documentation, Continue to 13*
- ☐ Patient has experienced a relapse post-hematopoietic stem cell transplant (HSCT) **ACTION REQUIRED:** *Submit supporting documentation, Continue to 13*
- ☐ None of the above, *Continue to 13*

12. 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 refractory disease **ACTION REQUIRED:** *Submit supporting documentation, Continue to 13*
- ☐ Patient has had 2 or more relapses **ACTION REQUIRED:** *Submit supporting documentation, Continue to 13*
- ☐ None of the above, *Continue to 13*

13. What is the patient's Karnofsky (age 16 years or older) or Lansky (age younger than 16 years) performance status?

\_\_\_\_\_, *Continue to 14*

14. What is the patient's age?

\_\_\_\_\_ years, *No Further Questions*

15. Has the patient received prior treatment with two or more lines of systemic therapy? **ACTION REQUIRED:** If Yes, attach chart notes, medical record documentation or claims history supporting previous lines of therapy.

- ☐ Yes, *Continue to 16*
- ☐ No, *Continue to 16*

16. Does the patient have primary central nervous system lymphoma?

- ☐ Yes, *Continue to 17*
- ☐ No, *Continue to 17*

17. Does the patient have an Eastern Cooperative Oncology Group (ECOG) performance status of 0 to 2 (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 18*
- ☐ No, *Continue to 18*

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18. What is the patient's age?  
\_\_\_\_\_ years, *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)**

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