Tecartus

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

 Tecartus SGM 4042-A – 01/2024.

Clinical Criteria Questions:

1. Has the patient received a previous treatment course of Tecartus (brexucabtagene 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 _____months, *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. What is the diagnosis?

❒ Mantle cell lymphoma, *Continue to 8*

❒ Acute lymphoblastic leukemia (ALL), *Continue to 11*

❒ Other, please specify. _____, *No Further Questions*

8. What is the clinical setting in which the requested medication will be used?

❒ Relapsed disease, *Continue to 9*

❒ Refractory disease, *Continue to 9*

❒ Other, please specify. _____, *Continue to 9*

9. Has the patient previously received chemoimmunotherapy? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical records or claims history supporting previous lines of therapy.
❒ Yes, *Continue to 10*
❒ No, *Continue to 10*

10. Has the patient previously received a bruton tyrosine kinase inhibitor (e.g., zanubrutinib)? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical records or claims history supporting previous lines of therapy.
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

11. Has the patient received a previous treatment course with any prior CD19 directed therapy other than blinatumomab (Blincyto)?

❒ Yes, *Continue to 12*
❒ No, *Continue to 12*

12. Does the patient have B-cell precursor acute lymphoblastic leukemia?
❒ Yes, *Continue to 13*
❒ No, *Continue to 13*

13. 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, *Continue to 14*

❒ No, *Continue to 14*

❒ Unknown or testing has not been completed, *Continue to 14*

14. Does the patient have active graft versus host disease?
❒ Yes, *Continue to 15*
❒ No, *Continue to 15*

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

❒ Philadelphia chromosome-positive disease, *Continue to 17*

❒ Philadelphia chromosome-negative disease, *Continue to 16*

❒ Unknown, *Continue to 16*

16. 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, *No Further Questions*

❒ Patient has had first relapse with remission of 12 months or less, *No Further Questions*
❒ Patient has relapsed or refractory disease after at least 2 previous lines of systemic therapy, *No Further Questions*
❒ Patient has relapsed or refractory disease after allogeneic stem cell transplant (allo-SCT), *No Further Questions*

❒ None of the above, *No Further Questions*

17. 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), *No Further Questions*

❒ Patient is intolerant to TKI therapy, *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)**

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