Yescarta

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:** ___________________
<u>Referring</u> Provider Info: ❑ **Same as Requesting Provider**
Name: ____ **NPI#:** _______________________________
Fax: _________________________ **Phone:** ______________________

<u>Rendering</u> 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.

<u>Required Demographic Information:</u>

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*

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

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received the fax in error, please immediately notify the sender by telephone and destroy the original fax message. Yescarta SGM – 05/2021.

Criteria Questions:

1. What is the diagnosis?
   ❑ Diffuse large B-cell lymphoma (DLBCL) arising from follicular lymphoma (also known as histologic transformation of follicular lymphoma to DLBCL)
   ❑ Histologic transformation of nodal marginal zone lymphoma to DLBCL
   ❑ Diffuse large B-cell lymphoma
   ❑ Primary mediastinal large B-cell lymphoma
   ❑ High-grade B-cell lymphoma (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)
   ❑ Acquired immunodeficiency syndrome (AIDS)-related B-cell lymphomas (including AIDS-related diffuse large B-cell lymphoma, primary effusion lymphoma, and human herpesvirus 8 (HHV8)-positive diffuse large B-cell lymphoma, not otherwise specific)
   ❑ Monomorphic post-transplant lymphoproliferative disorder (B-cell type)
   ❑ Follicular lymphoma
   ❑ Other ____
2. What is the ICD-10 code? ____________
3. Has the patient previously received one complete treatment course of Yescarta or another CD19-directed chimeric antigen receptor (CAR) T-cell therapy (e.g., Kymriah)? ❑ Yes ❑ No

Complete the following section based on the patient's diagnosis, if applicable.

Section A: Diffuse large B-cell lymphoma (DLBCL) arising from follicular lymphoma (also known as histologic transformation of follicular lymphoma to DLBCL) and histologic transformation of nodal marginal zone lymphoma to DLBCL

4. How many prior chemoimmunotherapy regimens has the patient received? _______________ regimens
5. Did at least one prior chemoimmunotherapy regimen received by the patient include an anthracycline or anthracenedione-based regimen? *If Yes, skip to Section C*
   ❑ Yes, anthracycline-based regimen ❑ Yes, anthracenedione-based regimen ❑ No
6. Are anthracycline and anthracenedione-based regimens contraindicated for the patient?
   If Yes, skip to Section C ❑ Yes ❑ No

Section B: Follicular Lymphoma

7. Does the patient have relapsed or refractory disease? ❑ Yes ❑ No
8. Has the patient received at least two or more lines of systemic therapy? *If Yes, go to Section C* ❑ Yes ❑ No

Section C: All Other B-Cell Lymphoma Subtypes and common requirements

9. Will Yescarta be used as subsequent treatment for the disease ? ❑ Yes ❑ No
10. Does the patient have primary central nervous system lymphoma? ❑ Yes ❑ No
11. Does the patient have CD19 positive disease that was confirmed by testing or analysis?
    ACTION REQUIRED: If Yes, attach results of testing or analysis confirming CD19 protein on the surface of the B-cell. ❑ Yes ❑ No ❑ Unknown

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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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