OKLAHOMA
Health Care Authority

State of Oklahoma
SoonerCare
Yescarta® (Axicabtagene Ciloleucel) Prior Authorization Form

Member Name:_____ Date of Birth:_____ Member ID#:_____

Drug Information

❑ ***Physician billing (HCPCS code:_____) Start Date:_____***

Billing Provider Information

SoonerCare Provider ID:_____ Provider Name:_____

Provider Phone:_____ Provider Fax:_____

Prescriber Information

Prescriber NPI:_____ Prescriber Name:_____

Prescriber Phone:_____ Prescriber Fax:_____ Specialty:_____

Criteria

For Authorization:

1. Please include the most recent office visit note or clinical summary from the hospital to support your request. Is this information attached? Yes___ No___
2. Is the health care facility on the certified list to administer CAR T-cells? Yes___ No___
3. Is the health care facility trained in the management of cytokine release syndrome (CRS) and neurologic toxicities? Yes___ No___
4. Will the health care facility comply with the Yescarta® REMS Program requirements? Yes___ No___
5. Please indicate the diagnosis and information:
   - ❑ **Large B-cell lymphoma**
     - A. Does diagnosis include diffuse large B-cell lymphoma (DLBCL), high grade B-cell lymphoma, DLBCL arising from follicular lymphoma (FL), or FL? Yes___ No___
     - B. If diagnosis includes DLBCL, high grade B-cell lymphoma, or DLBCL arising from FL, does member have primary central nervous system lymphoma? Yes___ No___
     - C. Is disease status refractory or relapsed? Yes___ No___
       - i. If refractory or relapsed disease, has member received 2 or more lines of therapy? Yes___ No___
         1. If yes, please provide additional information regarding previous therapies member has tried and failed:_____
       - ii. If refractory or relapsed disease, has member received 1 previous line therapy? Yes____ No____
         1. Is disease refractory to first-line chemotherapy? Yes____ No____
         2. Did relapse occur within 12 months of first-line chemotherapy? Yes____ No____
   - ❑ **If diagnosis is not listed above, please indicate diagnosis:**_____

Additional Information: _____

_____

_____

Prescriber Signature:_____ Date:_____

I certify that the indicated treatment is medically necessary and all information is true and correct to the best of my knowledge.

Failure to complete this form in full and attach requested clinical notes will result in processing delays.

PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:	CONFIDENTIALITY NOTICE
University of Oklahoma College of Pharmacy Pharmacy Management Consultants Product Based Prior Authorization Unit Fax: 1-800-224-4014 Phone: 1-800-522-0114 Option 4	*This document, including any attachments, contains information which is confidential or privileged. If you are not the intended recipient, be aware that any disclosure, copying, distribution, or use of the contents of this information is prohibited. If you have received this document in error, please notify the sender immediately by telephone to arrange for the return of the transmitted documents or to verify their destruction.*