OKLAHOMA Health Care Authority

State of Oklahoma
SoonerCare
Breyanzi® (Lisocabtagene Maraleucel) Prior Authorization Form

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

Drug Information

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

Billing Provider Information

Provider NPI:_____ ***Provider Name:***_____

Provider Phone:_____ ***Provider Fax:***_____

Prescriber Information

Prescriber NPI:_____ ***Prescriber Name:***_____

Prescriber Phone:_____ ***Prescriber Fax:***_____ ***Specialty:***_____

Criteria

For Authorization: *(approvals will be for 1 dose per member per lifetime)*

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 chimeric antigen receptor (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 Breyanzi® risk evaluation and mitigation strategy (REMS) program requirements? Yes☐ No☐
5. Please indicate the diagnosis and information:

☐ **Large B-cell Lymphoma**

A. Please provide additional information regarding previous therapies member has tried and failed:

_____

B. Does the member have any of the following?

- ☐ Refractory disease to frontline chemoimmunotherapy.
- ☐ Relapse within 12 months of frontline chemoimmunotherapy.
- ☐ Relapse after frontline chemoimmunotherapy and is not eligible for hematopoietic stem cell transplantion (HSCT) due to comorbidity or age.
- ☐ Relapsed or refractory disease after 2 or more lines of systemic therapy.

C. Does member have primary central nervous system (CNS) lymphoma? Yes☐ No☐

D. Please provide a patient-specific, clinically significant reason why Kymriah® (tisagenlecleucel) or Yescarta® (axicabtagene) is not appropriate for the member: _____

_____

☐ **If answer is none of the 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. *Please do not send in chart notes. Specific information will be requested if necessary. 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.*