

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:**

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 Kymriah® REMS Program requirements? Yes \_\_\_ No \_\_\_
5. Please indicate the diagnosis and information:
  - Acute Lymphoblastic Leukemia (ALL)**
    - A. Is diagnosis B-Cell precursor ALL? Yes \_\_\_ No \_\_\_
    - B. Is diagnosis Philadelphia chromosome negative (Ph-) ALL? Yes \_\_\_ No \_\_\_
    - C. Is diagnosis Philadelphia chromosome positive (Ph+) ALL? Yes \_\_\_ No \_\_\_
      - i. If Ph+ ALL, has member failed two or more Tyrosine Kinase Inhibitors (TKIs)?  
Yes \_\_\_ No \_\_\_
      - ii. Please list previously failed TKIs: \_\_\_\_\_
    - D. Is ALL refractory or relapsed? Yes \_\_\_ No \_\_\_
      - i. If relapsed, please specify number of relapses: \_\_\_\_\_Please provide additional information regarding previous therapies member has tried and failed:  
\_\_\_\_\_
  - Large B-cell lymphoma**
    - A. Is diagnosis Diffuse large B-cell lymphoma (DLBCL) not otherwise specified, primary mediastinal large B-cell lymphoma, high grade B-cell lymphoma, or DLBCL arising from follicular lymphoma)? Yes \_\_\_ No \_\_\_
    - B. Does member have primary central nervous system lymphoma? Yes \_\_\_ No \_\_\_
    - C. Is disease status refractory or relapsed after 2 or more lines of therapy? Yes \_\_\_ No \_\_\_
    - D. Please provide additional information regarding previous therapies member has tried and failed:  
\_\_\_\_\_
  - If answer is none of the above, please indicate diagnosis: \_\_\_\_\_

**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:

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

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