

**Breyanzi® (lisocabtagene maraleucel) Prior Authorization Form**

Member Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Member ID#: \_\_\_\_\_

**Drug Information**

Physician Billing (HCPCS code: \_\_\_\_\_) Start Date (or date of next dose): \_\_\_\_\_

**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 a qualified treatment center 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. 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 transplantation (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. A patient-specific, clinically significant reason why Kymriah® (tisagenlecleucel) or Yescarta® (axcabtagene) is not appropriate for the member: \_\_\_\_\_

\_\_\_\_\_

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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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Member Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Member ID#: \_\_\_\_\_

**Criteria**

For Authorization (continued):

5. Please indicate the diagnosis and information:

 **Chronic Lymphocytic Leukemia (CLL)/Small Lymphocytic Lymphoma (SLL)**

- A. Relapsed or refractory disease after 2 or more lines of systemic therapy? Yes \_\_\_ No \_\_\_  
i. Did therapy include a Burton tyrosine kinase (BTK) inhibitor and a B cell lymphoma-2 (BCL-2) inhibitor? Yes \_\_\_ No \_\_\_
- B. Does member have primary central nervous system (CNS) lymphoma? Yes \_\_\_ No \_\_\_

 **Follicular Lymphoma**

- A. Relapsed or refractory disease after 2 or more lines of systemic therapy? Yes \_\_\_ No \_\_\_
- B. Does member have primary central nervous system (CNS) lymphoma? Yes \_\_\_ No \_\_\_
- C. A patient-specific, clinically significant reason why Kymriah® (tisagenlecleucel) or Yescarta® (axcabtagene) is not appropriate for the member: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

 **Mantle Cell Lymphoma (MCL)**

- A. Relapsed or refractory disease after 2 or more lines of systemic therapy? Yes \_\_\_ No \_\_\_  
i. Did therapy include a Burton tyrosine kinase (BTK) inhibitor? Yes \_\_\_ No \_\_\_
- B. Does member have primary central nervous system (CNS) lymphoma? Yes \_\_\_ No \_\_\_
- C. A patient-specific, clinically significant reason why Tecartus® (brexucabtagene autoleucel) is not appropriate for the member: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

 **Marginal Zone Lymphoma (MZL)**

- A. Relapsed or refractory disease? Yes \_\_\_ No \_\_\_
- B. Has member received at least 2 prior lines of systemic therapy? Yes \_\_\_ No \_\_\_

 **Other:** \_\_\_\_\_Additional Information: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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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.**

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