

Yescarta[®] (axicabtagene ciloleucel) 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:

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 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. 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. 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 ___
 - a. 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 of therapy? Yes ___ No ___
 - a. Is disease refractory to first-line chemotherapy? Yes ___ No ___
 - b. 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:

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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