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 (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 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 ☐

☐ **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 ☐

☐ **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 ☐

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

CONFIDENTIALITY NOTICE

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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☐

☐ **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☐

☐ **Other:** _____

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.*

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