State of Oklahoma
SoonerCare
Kymriah® (tisagenlecleucel) Prior Authorization Form

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

Drug Information

☐ ***Physician billing*** **(HCPCS code:** _____**)** ☐ ***Pharmacy billing*** **(NDC:** _____**)**

Dose: _____ ***Regimen:*** _____ ***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 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:

☐ **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:

_____

☐ **Lymphoma**

A. Is diagnosis large B-cell lymphoma [including diffuse large B-cell lymphoma (DLBCL), high grade B-cell lymphoma, and DLBCL arising from follicular lymphoma (FL)] or 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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