HEALTHY U CHIP

PRIOR AUTHORIZATION REQUEST FORM
KYMRIAH®

For authorization, please answer each question and fax this form PLUS chart notes back to the Healthy U CHIP Prior Authorization Department at 801-213-1547.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have medical pharmacy prior authorization questions, please call for assistance: 833-981-0212

Disclaimer: Prior authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		HCPCS Code:

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Product being requested: ☐ Kymriah™ (tisagenlecleucel)

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section

Questions	Yes	No	Comments/Notes
1. Is the requesting provider in the Kymriah® REMS program?	☐	☐	
2. Does the member have an active infection, including hepatitis B, hepatitis C, human immunodeficiency virus (HIV), and influenza?	☐	☐	
3. Does the member have an inflammatory disorder?	☐	☐	
4. Does the member have adequate and stable liver, kidney, and cardiac function?	☐	☐	**Please provide documentation**
5. If the member is a sexually active female of reproductive age, a negative pregnancy test must be documented	☐	☐	**Please provide documentation**
6. Does the member have any of the following: • Isolated extra-medullary disease • Concomitant genetic syndrome associated with BM failure states • Burkitt's lymphoma/leukemia • Grade 2 to 4 graft versus host disease • CNS prophylaxis treatment • History of primary CNS lymphoma or active CNS involvement by malignancy • Worsening of leukemia burden following lymphodepleting chemotherapy	☐	☐	**Please provide documentation**
ACUTE LYMPHOBLATIC LEUKEMIA			
1. Is the request for treatment of acute lymphoblastic leukemia?	☐	☐	**Please Provide Documentation**

2. Is the member between the ages of 3-25 years?	☐	☐	**Please Provide Documentation**
3. Are B cells CD 19 positive as confirmed by testing or analysis?	☐	☐	**Please provide documentation**
4. Does the member have relapsed or refractory disease?	☐	☐	**Please provide documentation**
5. Does the member have a Karnofsky score or Lansky score > 50?	☐	☐	**Please provide documentation**
B- CELL LYMPHOMA			
1. Is the request for treatment of B-cell lymphoma?	☐	☐	**Please Provide Documentation**
2. Is the member at least 18 years of age?	☐	☐	**Please Provide Documentation**
3. Does the member have CD-19 positive disease?	☐	☐	**Please Provide Documentation**
4. Does the member have primary central nervous system lymphoma?	☐	☐	**Please Provide Documentation**
5. Does the member have an Eastern Cooperative Oncology Group (ECOG) Performance status of 0 or 1?	☐	☐	**Please Provide Documentation**
6. Has the member been unresponsive or refractory to at least 2 lines of systemic therapy, which must include anti CD-20 therapy and an anthracycline containing regimen?	☐	☐	**Please Provide Documentation**
7. Does the member have disease progression or relapse post-autologous stem cell transplant?	☐	☐	**Please Provide Documentation**
8. Does the member have any of the following: • Isolated extra-medullary disease • Concomitant genetic syndrome associated with BM failure states • Burkitt's lymphoma/leukemia • Grade 2 to 4 graft versus host disease • CNS prophylaxis treatment • History of primary CNS lymphoma or active CNS involvement by malignancy • Worsening of leukemia burden following lymphodepleting chemotherapy	☐	☐	**Please Provide Documentation**
REFACTORY FOLLICULAR LYMPHOMA			
1. Does documentation show a diagnosis of relapsing or refractory follicular lymphoma grade 1, 2, or 3A?	☐	☐	**Please Provide Documentation**
2. Is the member at least 18 years of age?			**Please Provide Documentation**
3. Does the member have an Eastern Cooperative Oncology Group (ECOG) Performance status of 0 or 1?	☐	☐	**Please Provide Documentation**

4. Does clinical documentation show ONE of the following criteria:
• No response or refractory to at least 2 lines of systemic therapy, which must include the following:
  ○ Anti-CD20 therapy
  ○ An alkylating containing regimen
• Disease progression or relapsed during or within 6 months of anti-CD20 maintenance therapy following at least 2 lines of systemic therapy
• Disease progression or relapse post-autologous stem cell transplant (ASCT)
	☐	☐	**Please Provide Documentation**

What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.			

Additional information:
Physician's Signature:

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Policy: PHARM-CHIP-M003
Origination Date: 07/01/2024
Reviewed/Revised Date:
Next Review Date:
Current Effective Date: 07/01/2024