HEALTHY U MEDICAID

PRIOR AUTHORIZATION REQUEST FORM
BREYANZI®

For authorization, please answer each question and fax this form PLUS chart notes back to the Healthy U Prior Authorization Department at 888-509-8142.

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

If you have prior authorization questions, please call for Pharmacy Customer Service for assistance at 855-856-5694

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: ☐ Breyanzi® (lisocabtagene maraleucel)

Dosing/Frequency:_____

Questions	Yes	No	Comments/Notes
1. Is the member 18 years of age of older?	☐	☐	
2. Does documentation show the member has relapsed or refractory large B-cell lymphoma, including one of the following: • Diffuse large B-cell lymphoma (DLBCL) not otherwise specified • High-grade B-cell lymphoma • Primary mediastinal large B-cell lymphoma • Follicular lymphoma grade 3B	☐	☐	**Please provide documentation**
3. Does the member have relapsed or refractory disease after at least 2 lines of systemic therapy, which must include both of the following: • Anti-CD20 therapy • Anthracycline containing regimen	☐	☐	**Please provide documentation**
4. Does the member have an Eastern Cooperative Oncology Group (ECOG) performance status of 0 or 1?	☐	☐	**Please provide documentation**
5. Does documentation show an absence of active infection, including Hepatitis B, Hepatitis C, Human Immunodeficiency Virus (HIV), and influenza?	☐	☐	**Please provide documentation**
6. Does the member have any of the following: • CrCl < 30mL/min • ALT > 5 times the upper limit of normal • Left ventricular ejection fraction < 40%	☐	☐	**Please provide documentation**

• History of chimeric antigen receptor therapy (CAR-T) or other genetically modified T-cell therapy			
7. For sexually active females of reproductive age, does the member have a negative pregnancy test within 1 month of therapy initiation?	☐	☐	**Please provide documentation**
8. Is the member and requesting provider enrolled in the Breyanzi® REMS program?	☐	☐	
9. Does the member have a history of primary central nervous system (CNS) lymphoma or active central nervous system (CNS) involvement by malignancy?	☐	☐	**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 Signature:			

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Policy PHARM-HU-M034
Origination Date: 01/01/2022
Reviewed/Revised Date: 05/17/2023
Next Review Date: 05/17/2024
Current Effective Date: 06/01/2023