HEALTH PLANS
UNIVERSITY OF UTAH

PRIOR AUTHORIZATION REQUEST FORM
YESCARTA®

For authorization, please answer each question and fax this form PLUS chart notes back to the U of U Health Plans 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 assistance: University of Utah Health Employees: 855-856-5690, Individual & Family Plans : 855-869-4769, Commercial Groups: 855-859-4892, MHC 855-885-7695

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:		

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: ☐ Yescarta® (axicabtagene ciloleucel)

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section

Questions	Yes	No	Comments/Notes
1. Is the request for Yescarta® for Relapse or Refractory Large B-cell Lymphoma?	☐	☐	
2. Is the request for Yescarta® for Relapse or Refractory Follicular Lymphoma?	☐	☐	
3. Is the member at least 18 years of age?	☐	☐	
4. Is the requesting provider in the Yescarta® REMS program?	☐	☐	
5. Does the member have CD-19 positive disease?	☐	☐	**Please provide documentation**
6. Does the member meet at least one of the following: • No response to at least 2 lines of systemic therapy which must include an anti CD-20 therapy and an anthracycline containing regimen • Disease progression or relapse post-autologous stem cell transplant (ASCT)	☐	☐	**Please provide documentation**
7. Has the member been found to be negative for active infections, including Hepatitis B, Hepatitis C, Human Immunodeficiency Virus (HIV), and influenza?	☐	☐	**Please provide documentation**
8. Does the member have adequate and stable kidney, liver, and cardiac function?	☐	☐	**Please provide documentation**
9. Does documentation show the members Eastern Cooperative Oncology Group (ECOG) Performance status?	☐	☐	**Please provide documentation**

10. If a sexually active female of reproductive age, does the member have a negative pregnancy test?	☐	☐	**Please provide documentation**
11. Does the member have any of the following: • Grade 2 to 4 graft versus host disease • Presence of an autoimmune disease requiring immune suppression • History of primary central nervous system lymphoma or active CNS involvement by malignancy • Cardiac ejection fraction <50%, evidence of pericardial effusion, or clinically significant pleural effusion	☐	☐	
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- M009
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