



## MEDICAL PHARMACY PRIOR AUTHORIZATION REQUEST FORM TECARTUS®

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

If you have prior authorization questions, please call Advantage U for assistance: 888-605-0858

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:**  Tecartus® (brexucabtagene autoleucl)

Dosing/Frequency: \_\_\_\_\_

**If the request is for reauthorization, proceed to reauthorization section.**

Questions	Yes	No	Comments/Notes
<b>MANTLE CELL LYMPHOMA</b>			
1. Is the member 18 years of age or older?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Does the member have a diagnosis of relapse or refractory mantle cell lymphoma?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
3. Was the member refractory, or had no response, to all of the following: <ul style="list-style-type: none"> <li>• Anthracycline or bendamustine-containing regimen</li> <li>• Anti-CD20 therapy, such as rituximab</li> <li>• Bruton’s Tyrosine Kinase (BTK) inhibitors, such as ibrutinib or acalabrutinib?</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
4. Does the member have a histological confirmation of cyclin D1 overexpression or presence of the translocation t(11;14)?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
5. Does the member have at least one measurable lesion per the Lugano Classification? <ul style="list-style-type: none"> <li>• Lymph nodes: the longest diameter in axial plane is &gt;1.5 cm</li> <li>• Extranodal lesions: the longest diameter in axial plane is &gt; 1.0 cm</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
6. Does the member have adequate bone marrow reserve with all of the following: <ul style="list-style-type: none"> <li>• Platelet count ≥ 75,000/μL</li> <li>• Absolute neutrophil count (ANC) ≥ 1,000 cells/μL</li> <li>• Absolute lymphocyte count (ALC) ≥ 100 cells/μL</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>

7. Does the member have a Karnofski score $\geq$ 70 or Eastern Cooperative Oncology Group (ECOG) score $<$ 2?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
8. Does the member have a documented ability to tolerate a lymphodepleting chemotherapy regimen of cyclophosphamide 500mg/m <sup>2</sup> intravenously and fludarabine 30mg/m <sup>2</sup> intravenously on the fifth, fourth, and third days before Tecartus™ infusion?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
9. Does the member have adequate and stable renal, cardiac, and pulmonary function with all of the following: <ul style="list-style-type: none"> <li>• Creatinine clearance <math>\geq</math> 60mL/min</li> <li>• Cardiac ejection fraction <math>\geq</math> 50% and no evidence of pericardial effusion determined by an echocardiogram</li> <li>• Baseline oxygen saturation <math>&gt;</math> 92% on room air?</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
10. Dose the member have any of the following: <ul style="list-style-type: none"> <li>• Previous allogeneic hematopoietic cell transplant (HSCT)</li> <li>• Prior treatment with chimeric antigen receptor therapy or other genetically modified T-cell therapy; or is being considered for treatment with any other gene therapy</li> <li>• Presence of fungal, bacterial, viral, or other infection that is uncontrolled requiring IV antimicrobials for management prior to Tecartus™ infusion</li> <li>• Active inflammatory disorders</li> <li>• Active hepatitis B (HBsAG positive) or hepatitis C (anti-HCV positive) virus, if viral load is detectable</li> <li>• History of central nervous system lymphoma</li> <li>• Active central nervous system (CNS) lymphoma or CNS disorders by imaging</li> <li>• Detectable malignant cells in the cerebrospinal fluid or brain metastases?</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	
11. Has the member received live vaccines within 6 weeks prior to the start of lymphodepleting chemotherapy?	<input type="checkbox"/>	<input type="checkbox"/>	
12. Will Tecartus™ be given at a certified center to administer Tecartus™?	<input type="checkbox"/>	<input type="checkbox"/>	
13. Has the member and the requesting provider enrolled in the Yescarta® and Tecartus™ REMS program?	<input type="checkbox"/>	<input type="checkbox"/>	
<b>B-CELL PRECURSOR ACUTE LYMPHOBLASTIC LEUKEMIA (ALL)</b>			
1. Has the member received a previous treatment course of the requested medication or another CD19-directed chimeric antigen receptor (CAR-T) therapy, or any prior CD19 directed therapy other than blinatumomab?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
2. Does the member have Philadelphia chromosome-negative disease that is relapsed or refractory as defined as one of the following: <ul style="list-style-type: none"> <li>• Primary refractory disease; <i>or</i></li> <li>• First relapse with remission of 12 months or less; <i>or</i></li> <li>• Relapsed or refractory disease after at least 2 previous lines of systemic therapy; <i>or</i></li> <li>• Relapsed or refractory disease after allogeneic stem cell transplant (allo-SCT)</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>

**Confidentiality Notice**

This document and any accompanying document contain confidential information and is intended for the use of the individual or entity named on this transmission sheet. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or the taking of any action in reliance on the contents of this information is strictly prohibited and the document should be returned to this office immediately. If you have received this facsimile in error, please notify us by telephone immediately and destroy document received.

3. Does the member have Philadelphia chromosome-positive disease and meets either of the following: <ul style="list-style-type: none"> <li>Relapsed or refractory disease despite treatment with at least 2 different tyrosine kinase inhibitors (TKIs) (e.g., bosutinib, dasatinib, imatinib, nilotinib, ponatinib); or</li> <li>The member is intolerant to TKI therapy</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
4. Does the member have morphological disease in the bone marrow?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
5. Does the member have an ECOG performance status of 0 to 2?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
6. Does the member have adequate and stable kidney, liver, pulmonary, and cardiac function?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
7. Does the member have active hepatitis B, active hepatitis C, or any active uncontrolled infection?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
8. Does the member have active graft versus host disease?	<input type="checkbox"/>	<input type="checkbox"/>	
9. Does the member have an active inflammatory disorder?	<input type="checkbox"/>	<input type="checkbox"/>	
<b>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.</b>			
Additional information:			
Physician Signature:			

Policy: PHARM-MA-M031  
 Origination Date: 01/01/2022  
 Reviewed/Revised Date: 01/19/2022  
 Next Review Date: 01/19/2023  
 Current Effective Date: 02/01/2022

**Confidentiality Notice**

This document and any accompanying document contain confidential information and is intended for the use of the individual or entity named on this transmission sheet. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or the taking of any action in reliance on the contents of this information is strictly prohibited and the document should be returned to this office immediately. If you have received this facsimile in error, please notify us by telephone immediately and destroy document received.