



Kymriah

Prior Authorization Request

CVS Caremark administers the prescription benefit plan for the member identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-844-823-5477.** If you have questions regarding the prior authorization, please contact CVS Caremark at **1-800-469-7556**. For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

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Patient's Name: _____ **Date:** _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____ **NPI#:** _____
Specialty: _____ **Physician Office Fax:** _____
Physician Office Telephone: _____

Referring Provider Info: Same as Requesting Provider

Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Rendering Provider Info: Same as Referring Provider Same as Requesting Provider

Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Required Demographic Information:

Patient Weight: _____ kg

Patient Height: _____ cm

Please indicate the place of service for the requested drug:

- Ambulatory Surgical Home Off Campus Outpatient Hospital
 On Campus Outpatient Hospital Office Pharmacy

Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-844-823-5477

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received the fax in error, please immediately notify the sender by telephone and destroy the original fax message. Kymriah SGM 2294-A – 10/2022.

CVS Caremark Specialty Pharmacy • 2211 Sanders Road NBT-6 • Northbrook, IL 60062

Phone: 1-800-469-7556 • Fax: 1-844-823-5477 • www.caremark.com

Criteria Questions:

1. What is the diagnosis?
 - Acute lymphoblastic leukemia (ALL)
 - Diffuse large B-cell lymphoma (DLBCL) arising from follicular lymphoma
 - Follicular lymphoma (FL)
 - Histologic transformation of indolent lymphomas to DLBCL
 - Diffuse large B-cell lymphoma
 - High-grade B-cell lymphoma (including high-grade B-cell lymphoma with translocations of MYC and BCL2 and/or BCL6 [double/triple hit lymphoma], high-grade B-cell lymphoma, not otherwise specified)
 - Acquired immunodeficiency syndrome (AIDS)-related B-cell lymphomas (including AIDS-related diffuse large B-cell lymphoma, primary effusion lymphoma, and human herpesvirus 8 (HHV8)-positive diffuse large B-cell lymphoma, not otherwise specific)
 - Monomorphic post-transplant lymphoproliferative disorder (B-cell type)
 - Other _____
2. What is the ICD-10 code? _____
3. Has the patient previously received one complete treatment course of Kymriah or another CD19-directed chimeric antigen receptor (CAR) T-cell therapy (e.g., Yescarta)? Yes No
4. Does the patient have adequate and stable kidney, liver, pulmonary and cardiac function? Yes No
5. Does the patient have active or latent hepatitis B, active hepatitis C, or any active uncontrolled infection? Yes No
6. Does the patient have active graft versus host disease? Yes No
7. Does the patient have an active inflammatory disorder? Yes No

Complete the following section based on the patient's diagnosis, if applicable.

Section A: Acute Lymphoblastic Leukemia (ALL)

8. Does the patient have B-cell precursor acute lymphoblastic leukemia? Yes No
9. Does the patient have CD19 tumor expression in bone marrow or peripheral blood?
ACTION REQUIRED: If Yes, attach results of testing or analysis confirming CD19 tumor expression in bone marrow or peripheral blood. Yes No Unknown or testing has not been completed
10. Does the patient have at least 5% lymphoblasts in the bone marrow? **ACTION REQUIRED: If Yes, attach results of testing or analysis confirming at least 5% lymphoblasts in the bone marrow.**
 Yes No Unknown or testing has not been completed
11. What is the Philadelphia chromosome status for the patient's disease?
 - Philadelphia chromosome-positive disease
 - Philadelphia chromosome-negative disease
 - Unknown
12. Does the patient meet any of the following? **ACTION REQUIRED: Attach chart notes, medical record documentation or claims history supporting previous lines of therapy.**
 - Patient has refractory disease
 - Patient has had 2 or more relapses
 - Patient has had 2 or more relapses AND has failed at least 2 tyrosine kinase inhibitors (TKIs) (e.g., bosutinib, dasatinib, imatinib, nilotinib, ponatinib)
 - Patient has relapsed disease and is TKI intolerant
 - Patient has experienced a relapse post-hematopoietic stem cell transplant (HSCT)
 - None of the above
13. What is the patient's Karnofsky (age 16 years or older) or Lansky (age younger than 16 years) performance status?
_____ %

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Section B: B-Cell Lymphomas

14. Has the patient received prior treatment with two or more lines of systemic therapy?
ACTION REQUIRED: If Yes, attach chart notes, medical record documentation or claims history supporting previous lines of therapy. Yes No
15. Does the patient have primary central nervous system lymphoma? Yes No
16. Does the patient have an Eastern Cooperative Oncology Group (ECOG) performance status of 0 to 2 (patient is ambulatory and capable of all self-care but unable to carry out any work activities. Up and about more than 50% of waking hours)? Yes No

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X _____

Prescriber or Authorized Signature

Date (mm/dd/yy)

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