



## Yescarta

### Prior Authorization Request

CVS Caremark administers the prescription benefit plan for the patient 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 1-855-330-1720.** If you have questions regarding the prior authorization, please contact CVS Caremark at **1-888-877-0518**. 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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<b>Patient's Name:</b> _____	<b>Date:</b> _____
<b>Patient's ID:</b> _____	<b>Patient's Date of Birth:</b> _____
<b>Physician's Name:</b> _____	
<b>Specialty:</b> _____	<b>NPI#:</b> _____
<b>Physician Office Telephone:</b> _____	<b>Physician Office Fax:</b> _____
<b>Referring Provider Info:</b> <input type="checkbox"/> Same as Requesting Provider	
<b>Name:</b> _____	<b>NPI#:</b> _____
<b>Fax:</b> _____	<b>Phone:</b> _____
<b>Rendering Provider Info:</b> <input type="checkbox"/> Same as Referring Provider <input type="checkbox"/> Same as Requesting Provider	
<b>Name:</b> _____	<b>NPI#:</b> _____
<b>Fax:</b> _____	<b>Phone:</b> _____

*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:*

- |  |                                 |   |
|--|---------------------------------|---|
| <input type="checkbox"/> Ambulatory Surgical           | <input type="checkbox"/> Home   | <input type="checkbox"/> Off Campus Outpatient Hospital |
| <input type="checkbox"/> On Campus Outpatient Hospital | <input type="checkbox"/> Office | <input type="checkbox"/> Pharmacy                       |

**Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-855-330-1720**

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. Yescarta SGM\* – 05/2022.

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

**Phone: 1-888-877-0518 • Fax: 1-855-330-1720 • www.caremark.com**

**Criteria Questions:**

1. Has the patient previously received one complete treatment course of Yescarta or another CD19-directed chimeric antigen receptor (CAR) T-cell therapy (e.g., Brevanzi, Kymriah)?  Yes  No
2. What is the ICD-10 code? \_\_\_\_\_
3. What is the diagnosis?
  - Diffuse large B-cell lymphoma (DLBCL) arising from follicular lymphoma (also known as histologic transformation of follicular lymphoma to DLBCL) *skip to #5*
  - Histologic transformation of nodal marginal zone lymphoma to DLBCL *skip to #5*
  - Diffuse large B-cell lymphoma (DLBCL)
  - Primary mediastinal large B-cell lymphoma
  - High-grade B-cell lymphoma (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 specified)
  - Monomorphic post-transplant lymphoproliferative disorder (B-cell type)
  - Follicular lymphoma *skip to #5*
  - Gastric MALT lymphoma *skip to #5*
  - Nongastric MALT lymphoma *skip to #5*
  - Nodal marginal zone lymphoma *skip to #5*
  - Splenic marginal zone lymphoma *skip to #5*
  - Other \_\_\_\_\_
4. Has the patient received prior treatment with first-line chemoimmunotherapy (e.g., RCHOP [rituximab, cyclophosphamide, doxorubicin, vincristine, prednisone])? **Action Required: If 'Yes', please attach chart notes, medical records or claims history supporting previous lines of therapy.**  Yes *If Yes, skip to #6*  No
5. Has the patient received prior treatment with two or more lines of systemic therapy? **ACTION REQUIRED: Attach chart notes, medical record documentation or claims history supporting previous lines of therapy.**  Yes  No
6. Does the patient have adequate and stable kidney, liver, pulmonary and cardiac function?  Yes  No
7. Does the patient have active hepatitis B, active hepatitis C, or a clinically significant active systemic infection?  Yes  No
8. Does the patient have an active inflammatory disorder?  Yes  No
9. Does the patient have primary central nervous system lymphoma?  Yes  No
10. Does the patient have an Eastern Cooperative Oncology Group (ECOG) performance status of 0 to 2 (patient 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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