Tecartus

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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Patient's Name: ______________________________ **Date**: ________________________________
Patient's ID: ________________________________ **Patient's Date of Birth:** ________________
Physician's Name: ____
Specialty: __________________________________ **NPI#:** _________________________________
Physician Office Telephone: __________________ **Physician Office Fax:** ___________________

Referring Provider Info: ❑ **Same as Requesting Provider**
Name: ____ **NPI#:** ______________________________
Fax: _________________________ **Phone:** ______________________
6

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*

Clinical Criteria Questions:

1. What is the diagnosis?
   ❑ Mantle cell lymphoma (MCL)
   ❑ Acute lymphoblastic leukemia (ALL)
   ❑ Other ____

2. What is the ICD-10 code? _____________

3. Has the patient received a previous treatment course of Tecartus (brexucabtagene autoleucel) or another CD19-directed chimeric antigen receptor (CAR) T-cell therapy? ❑ Yes ❑ No

4. Does the patient have an Eastern Cooperative Oncology Group (ECOG) performance status of 0 or 2 (the 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

5. Does the patient have adequate and stable kidney, liver, pulmonary and cardiac function? ❑ Yes ❑ No

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

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6. Does the patient have active or latent hepatitis B, active hepatitis C, or any active uncontrolled infection?
   ❑ 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: Mantle Cell Lymphoma (MCL)

8. Is the patient's disease relapsed or refractory? ❑ Yes ❑ No

9. Has the patient previously received chemoimmunotherapy? ***ACTION REQUIRED: If Yes, please attach chart notes, medical records or claims history supporting previous lines of therapy.*** ❑ Yes ❑ No

10. Has the patient previously received a bruton tyrosine kinase inhibitor (e.g., ibrutinib)?
    ACTION REQUIRED: If Yes, please attach chart notes, medical records or claims history supporting previous lines of therapy. ❑ Yes ❑ No

Section B: Acute Lymphoblastic Leukemia (ALL)

11. Has the member received a previous treatment course with any prior CD19 directed therapy other than blinatumomab? ❑ Yes ❑ No

12. Does the patient have B-cell precursor acute lymphoblastic leukemia? ❑ Yes ❑ No

13. Does the patient have morphological disease in the bone marrow (greater than or equal to 5% blasts)?
    ACTION REQUIRED: If Yes, please attach results of testing or analysis confirming 5% or greater blasts in the bone marrow. ❑ Yes ❑ No

14. Does the patient have active graft versus host disease? ❑ Yes ❑ No

15. What is the Philadelphia chromosome status for the patient's disease?
    ❑ Philadelphia chromosome-positive disease
    ❑ Philadelphia chromosome-negative disease
    ❑ Unknown

16. Does the patient meet any of the following? *Indicate ALL that apply.* ***ACTION REQUIRED: Attach chart notes, medical record documentation or claims history supporting previous lines of therapy.***
    ❑ Patient has primary refractory disease
    ❑ Patient has had first relapse with remission of 12 months or less
    ❑ Patient has relapsed or refractory disease after at least 2 previous lines of systemic therapy
    ❑ Patient has relapsed or refractory disease after allogeneic stem cell transplant (allo-SCT)
    ❑ Patient has relapsed or refractory disease despite treatment with at least 2 different tyrosine kinase inhibitors (TKIs) (e.g., bosutinib, dasatinib, imatinib, nilotinib, ponatinib
    ❑ Patient is intolerant to TKI therapy
    ❑ None of the above

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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