Kymriah

Prior Authorization Request

CVS Caremark administers the medical drug prior authorization program on behalf of Harvard Pilgrim Health Care. Your patient's benefit plan requires prior authorization for certain medications. In order to make appropriate medical necessity determinations, your patient's diagnosis and other clinical information is required. **Please complete the information requested on the form below and fax this form to CVS Caremark, toll-free at 1-844-851-0882** to initiate the review process. If you have questions regarding the prior authorization please contact CVS Caremark at **1-844-387-1435.**

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Patient's Name: ______________________________ **Date**: ___________________________________
Patient's ID: ________________________________ **Patient's Date of Birth:** __________________
Physician's Name: ____________________________ **NPI#:** ___________________________________
Specialty: __________________________________ **HPHC Provider ID**_______________________
Physician Office Telephone: __________________ **Physician Office Fax:** _____________________

<u>Rendering</u> Provider Info: ❑ Same as Requesting Provider **HPHC Provider ID:**_______________________
Name: ____ **NPI#:** ___________________________________
Fax: _____________________ **Phone:** __________________ **Provider Tax ID:** _________________________

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

<u>Additional Demographic Information:</u>

Please indicate the place of service for the requested drug:
❑ Ambulatory Surgical ❑ Home ❑ Inpatient Hospital ❑ Off Campus Outpatient Hospital
❑ On Campus Outpatient Hospital ❑ Office ❑ Pharmacy

<u>Drug Information:</u>

*Strength/Measure*______________________________ *Units* ❑ ml ❑ Gm ❑ mg ❑ ea ❑ Un
*Directions(sig)*_________________________________ *Route of administration*________________________
*Dosing frequency*______________________________

<u>Criteria Questions:</u>

1. What is the diagnosis?
   ❑ B-cell precursor acute lymphoblastic leukemia (ALL)
   ❑ Large B-cell lymphoma (including diffuse large B-cell lymphoma (DLBCL) not otherwise specified, primary mediastinal large B-cell lymphoma, high grade B-cell lymphoma, and DLBCL arising from follicular lymphoma)
   ❑ Other ____
2. What is the ICD-10 code? _____________
3. Has the patient been approved for Kymriah previously? ❑ Yes ❑ No
4. Has testing or analysis been performed to identify the CD19 antigen on the surface of the B-cell?
   ACTION REQUIRED: Attach a copy of the CD19 protein test result.
   ❑ Yes ❑ No ❑ Unknown
5. Is the cancer CD19 positive? ❑ Yes ❑ No

Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-844-851-0882

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CVS Caremark Specialty Pharmacy ● 2211 Sanders Road NBT-6 ● Northbrook, IL 60062
Phone: 1-844-387-1435 ● Fax: 1-844-851-0882 ● www.caremark.com

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

Section A: Acute Lymphoblastic Leukemia (ALL)

6. Is the patient's disease refractory to treatment or in second or later relapse?
   ❑ Refractory to treatment ❑ Second or later relapse ❑ Other ___________________________________

Section B: Large B-Cell Lymphoma

7. Is the patient's disease refractory to treatment or relapsed after two or more lines of systemic therapy?
   ❑ Refractory to treatment ❑ Relapsed after two or more lines of systemic therapy
   ❑ Other ___________________________________

8. Does the patient have primary central nervous system lymphoma? ❑ Yes ❑ No ❑ Unknown

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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