Blue Cross Blue Shield/Blue Care Network of Michigan
Medication Authorization Request Form

Blue Cross Blue Shield Blue Care Network of Michigan

Nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association

This form is to be used by participating physicians to obtain coverage for **drugs covered under the medical benefit**. For commercial members only, please complete this form and submit via fax to 1-877-325-5979. If you have any questions regarding this process, please contact BCBSM Provider Relations and Servicing or the Medical Drug Helpdesk at 1-800-437-3803 for assistance.

PATIENT INFORMATION		PHYSICIAN INFORMATION
Name		**Name**
ID Number		**Specialty**
D.O.B.	_____/_____/_____ MM/DD/YYYY ❑Male ❑Female	**Address**
Diagnosis		**City /State/Zip**
Drug Name	**Kymriah**	**Phone:** **Fax:**
Dose and Quantity		**NPI**
Directions		**Contact Person**
Date of Service(s)		**Contact Person** **Phone / Ext.**

STEP 1: DISEASE STATE INFORMATION

Required Demographic Information:

Patient Weight: _____*kg*

Patient Height: _____*ft* _____*inches*

Will the provider be administering the medication to the FEP member within the health plan's geographic service area?

❑ Yes ❑ No *If No, a prior authorization is not required through this process*.

Prior authorizations are required for FEP members that will be serviced by a provider within the health plan's geographic service area. If you are not a provider in the geographic service area, please contact the health plan for questions regarding the FEP member's benefit requirements.

Is this member's FEP coverage primary or secondary coverage?

❑ If primary, continue with question set.

❑ If secondary, **an authorization is not needed through this process. Please contact the member's primary coverage for determination of benefit and additional information.**

Criteria Questions:

1. What is the patient's diagnosis?

❑ Refractory or relapsed B-cell precursor acute lymphoblastic leukemia (ALL)

a. Does the patient have Philadelphia chromosome-positive (Ph+) ALL? ❑Yes* ❑No
If YES, has the patient received a prior regimen containing 2 lines of tyrosine kinase inhibitor therapy (TKI)? ❑Yes ❑N
b. Has the patient received a prior regimen containing two lines of tyrosine kinase inhibitor therapy (TKI)? ❑Yes ❑No*
If NO, has the patient received a prior regimen containing 2 cycles of a standard chemotherapy regimen? ❑Yes ❑No
c. Does the patient have documentation of CD19 tumor expression in either bone morrow or peripheral blood? ❑Yes ❑No
d. Does the patient have lymphoblasts greater than or equal to 5%? ❑Yes ❑No
e. Has the patient had adequate organ function with no significant deterioration in organ function expected within 4 weeks after apheresis? ❑Yes ❑No
f. Does the patient have a diagnosis of Burkitt lymphoma? ❑Yes ❑No
g. Does the patient have a diagnosis of grade 2 to 4 graft-versus-host disease (GvHD)? ❑Yes ❑No
h. Does the patient have a concomitant genetic syndrome associated with bone marrow failure with the exception of Down syndrome? ❑Yes ❑No
i. Will the patient have received allogenic cellular therapy within 6 weeks prior to Kymriah infusion? ❑Yes ❑No
j. Does the patient have active central nervous system acute lymphoblastic leukemia (i.e., white blood cell count greater than or equal to 5 cells/μL in cerebrospinal fluid with presence of lymphoblasts)? ❑Yes ❑No

❑ Refractory or relapsed Diffuse Large B-Cell Lymphoma (DLBCL)

a. Has the patient received two or more lines systemic therapy that include anti-CD20 monoclonal antibody for CD20-positive tumor and anthracycline-containing chemotherapy regimen? ❑Yes ❑No
b. Does that patient have any active central nervous system malignancy? ❑Yes ❑No
c. Has the patient had adequate organ and bone marrow function as determined by the prescriber? ❑Yes ❑No

❑ Diffuse Large B-Cell Lymphoma (DLBCL) arising from follicular lymphoma (FL)

a. Has the patient had prior chemotherapy for follicular lymphoma and subsequently has chemorefractory disease? ❑Yes ❑No

b. Has the patient had anti-CD20 monoclonal antibody for CD20-positive tumor therapy? ❑Yes ❑No*
If NO, has the patient had an anthracycline-containing chemotherapy regimen? ❑Yes ❑No
c. Does that patient have any active central nervous system malignancy? ❑Yes ❑No
d. Has the patient had adequate organ and bone marrow function as determined by the prescriber? ❑Yes ❑No

❑ High grade B-cell lymphoma
a. Has the patient received two or more lines of systemic therapy that include anti-CD20 monoclonal antibody for CD20-positive tumor and anthracycline-containing chemotherapy regimen? ❑Yes ❑No
b. Does that patient have any active central nervous system malignancy? ❑Yes ❑No
c. Has the patient had adequate organ and bone marrow function as determined by the prescriber? ❑Yes ❑No

❑ Relapsed or refractory Follicular lymphoma (FL)
a. Has the patient received two or more lines of systemic therapy for the treatment of follicular lymphoma (FL)? ❑Yes ❑No
b. Does that patient have any active central nervous system malignancy? ❑Yes ❑No
c. Has the patient had adequate organ and bone marrow function as determined by the prescriber? ❑Yes ❑No

❑ Other diagnosis ***(please specify)***: _____

2. Does the patient have any active infections including tuberculosis (TB), hepatitis B virus (HBV), hepatitis C virus (HCV), or human immunodeficiency virus (HIV)? ❑Yes ❑No

3. Is the patient at risk for hepatitis B virus (HBV) infection? ❑Yes* ❑No
If YES, has the HBV infection been ruled out or has the patient already started treatment for HBV infection? ❑Yes ❑No

4. Does the prescriber agree to monitor the patient for signs and symptoms of cytokine release syndrome (CRS) and administer tocilizumab (Actemra) if needed? ❑Yes ❑No

5. Does the prescriber agree to monitor the patient for signs and symptoms of neurological toxicities? ❑Yes ❑No

6. Will Kymriah be administered in a healthcare facility enrolled in the Kymriah REMS Program? ❑Yes ❑No

7. Has the patient previously received any other therapy treatment such as Abecma, Breyanzi, Carvykti, Tecartus, or Yescarta? ❑Yes* ❑No ***If YES***, please specify: _____
_____

8. Will Kymriah be used in combination with any other gene therapy treatment such as Abecma, Breyanzi, Carvykti, Tecartus, or Yescarta? ❑Yes* ❑No ***If YES***, please specify: _____

Chart notes are required for the processing of all requests. Please add any other supporting medical information necessary for our review **(required)**

Coverage will not be provided if the prescribing physician's signature and date are not reflected on this document.

❑ Request for expedited review: I certify that applying the standard review time frame may seriously jeopardize the life or health of the member or the member's ability to regain maximum function

Physician's Name	**Physician Signature**	**Date**
Step 2: Checklist	❑ Form Completely Filled Out ❑ Provide chart notes	❑ Attach test results
Step 3: Submit	**By Fax: BCBSM Specialty Pharmacy Mailbox** **1-877-325-5979**	**By Mail: BCBSM Specialty Pharmacy Program** **P.O. Box 312320, Detroit, MI 48231-2320**