



Commonwealth of Massachusetts
MassHealth Drug Utilization Review Program
 P.O. Box 2586, Worcester, MA 01613-2586
Fax: (877) 208-7428 **Phone:** (800) 745-7318

Chimeric Antigen Receptor (CAR)-T Immunotherapies Prior Authorization Request

MassHealth reviews requests for prior authorization (PA) on the basis of medical necessity only. If MassHealth approves the request, payment is still subject to all general conditions of MassHealth, including current member eligibility, other insurance, and program restrictions. MassHealth will notify the requesting provider and member of its decision. Keep a copy of this form for your records. If faxing this form, please use black ink.

Additional information about these agents, including PA requirements and preferred products, can be found within the MassHealth Drug List at www.mass.gov/druglist.

Member information

Last name _____ First name _____ MI _____
 MassHealth member ID # _____ Date of birth _____
 Gender (Check one.) F M Member's place of residence home nursing facility

Medication information

Medication requested

Kymriah (tisagenlecleucel)^ Yescarta (axicabtagene ciloleucel)^

Dose, frequency, and duration of medication requested

Indication (Check all that apply.)

*Kymriah requests only **Yescarta requests only

- | | |
|--|--|
| <input type="checkbox"/> B-cell precursor acute lymphoblastic leukemia (ALL) that is refractory or in second or later relapse*
<input type="checkbox"/> Relapsed or refractory large B-cell lymphoma after two or more lines of systemic therapy, including diffuse large B-cell lymphoma (DLBCL) not otherwise specified (NOS), high grade B-cell lymphoma, and DLBCL arising from follicular lymphoma (FL)* | <input type="checkbox"/> Relapsed or refractory large B-cell lymphoma after two or more lines of systemic therapy, including DLBCL NOS, primary mediastinal large B-cell lymphoma, high grade B-cell lymphoma, and DLBCL arising from FL** |
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^This drug is available through the health care professional who administers the drug. MassHealth does not pay for this drug to be dispensed through a retail pharmacy.

Please indicate prescriber specialty below.

Hematology Oncology Other _____

Section I. Please complete for all requests.

- Member's current weight _____ Date _____
- Please provide anticipated dates for the following as applicable.
 Treatment date _____ Leukapheresis _____ Admission _____ Infusion _____ Discharge _____
- Please provide the infusion setting. Inpatient Outpatient
- Will the infusion take place in a health care facility that has been certified pursuant to the Risk Evaluation and Mitigation Strategy (REMS) program specific to the treatment being provided? Yes No

5. Please list any other prior trials. Please list the drug names, dates/duration of use and outcomes below.*
 Drug _____ Dates/duration _____ Adverse reaction Inadequate response Other
 Briefly describe details of adverse reaction, inadequate response, or other.
- _____
 Drug _____ Dates/duration _____ Adverse reaction Inadequate response Other
 Briefly describe details of adverse reaction, inadequate response, or other.
6. Outreach for both short- and long-term monitoring for efficacy and durability of response will be conducted by MassHealth. The applicable information [including but not limited to: medical records, dates of procedures, infusions, and admissions; adverse reactions experienced; agents used to treat adverse reactions; response to therapy (e.g. complete blood count, bone marrow blasts, peripheral blood blasts, platelets, absolute neutrophil counts)] will be provided to MassHealth upon request. Yes No

Section II. Please also complete for Kymriah requests for a diagnosis of B-cell precursor acute lymphoblastic leukemia (ALL) that is refractory or in second or later relapse.

1. Please attach a letter from the hospital financial department addressing participation status in the manufacturer's outcomes-based contract.
2. Please indicate Philadelphia chromosome type. Positive Negative
 If positive, has the member failed two kinase inhibitors? Yes. Please provide details below.* No
 Drug _____ Dates/duration _____ Outcome _____
 Drug _____ Dates/duration _____ Outcome _____
3. Does the member have refractory disease? Yes No
4. Please provide the number of relapses. _____

Section III. Please complete for all requests for non-preferred drug products if one or more preferred drug products have been designated for this class of drugs.

If one or more preferred drug products have been designated for this class of drugs, and if you are requesting PA for a non-preferred drug product, please provide medical necessity for prescribing the non-preferred drug product rather than the preferred drug product.

*Attach a letter with additional information regarding medication trials as applicable.

Prescriber information

Last name* _____ First name* _____ MI _____
 NPI* _____ Individual MH Provider ID _____
 DEA No. _____ Office Contact Name _____
 Address _____ City _____ State _____ Zip _____
 E-mail address _____
 Telephone No.* _____ Fax No.* _____

* Required

Prescribing provider's attestation, signature, and date

I certify under the pains and penalties of perjury that I am the prescribing provider identified in the Prescriber information section of this form. Any attached statement on my letterhead has been reviewed and signed by me. I certify that the medical necessity information (per 130 CMR 450.204) on this form is true, accurate, and complete, to the best of my knowledge. I understand that I may be subject to civil penalties or criminal prosecution for any falsification, omission, or concealment of any material fact contained herein.

Prescribing provider's signature (Signature and date stamps, or the signature of anyone other than the provider, are not acceptable.)

Signature required _____

Printed name of prescribing provider _____ Date _____