

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



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 <input type="checkbox"/> Male <input type="checkbox"/> Female	Address
Diagnosis	City /State/Zip
Drug Name Kymriah	Phone:
Dose and Quantity	Fax:
Directions	NPI
Date of Service(s)	Contact Person
	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. 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

b. Does the patient have documentation of CD19 tumor expression in either bone marrow or peripheral blood? Yes No

c. Does the patient have lymphoblasts greater than or equal to 5%? Yes No

d. Has the patient had adequate organ function with no significant deterioration in organ function expected within 4 weeks after apheresis? Yes No

e. Does the patient have Burkitt lymphoma or grade 2 to 4 graft-versus-host disease (GvHD)? Yes No

f. Does the patient have a concomitant genetic syndrome associated with bone marrow failure other than Down syndrome? Yes No

g. Will the patient have received allogenic cellular therapy within 6 weeks prior to Kymriah infusion? Yes No

h. 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. Does the patient have diffuse large B-cell lymphoma arising from follicular lymphoma? **Select answer below:**

Yes, please answer the following questions:

i. Has the patient had prior chemotherapy for follicular lymphoma and subsequently has chemorefractory disease?

Yes No

ii. 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

No: 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

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

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, 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, 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	<input type="checkbox"/> Form Completely Filled Out <input type="checkbox"/> Provide chart notes	<input type="checkbox"/> 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

Confidentiality notice: This transmission contains confidential information belonging to the sender that is legally privileged. This information is intended only for use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reliance on the contents of this document is strictly prohibited. If you have received this in error, please notify the sender to arrange for the return of this document.