Kymriah

Prior Authorization Request

Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-844-823-5477

CVS Caremark administers the prescription benefit plan for the member 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 1-844-823-5477**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-800-469-7556.** 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.

The recipient of this fax may make a request to opt-out of receiving telemarketing fax transmissions from CVS Caremark. There are numerous ways you may opt-out: The recipient may call the toll-free number at 877-265-2711, at any time, 24 hours a day/7 days a week. The recipient may also send an opt-out request via email to do_not_call@cvscaremark.com. An opt out request is only valid if it (1) identifies the number to which the request relates, and (2) if the person/entity making the request does not, subsequent to the request, provide express invitation or permission to CVS Caremark to send facsimile advertisements to such person/entity at that particular number. CVS Caremark is required by law to honor an opt-out request within thirty days of receipt.

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:** _____

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* ❑ *Inpatient Hospital* ❑ *Off Campus Outpatient Hospital*
❑ *On Campus Outpatient Hospital* ❑ *Office* ❑ *Pharmacy*

Criteria Questions:

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

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)**