

**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.

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**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

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**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)**