Axicabtagene ciloleucel (Yescarta)

Prior Authorization Form/Prescription

Date: __________ Date Medication Required: __________
Ship to: ❍ Physician ❍ Patient's Home ❍ Other: ________

Health Net Health Plan of Oregon, Inc.
Health Net Life Insurance Company

Prior Authorization / Formulary Exception Request Fax Form

FAX TO: (800) 255-9198

Form must be fully completed to avoid a processing delay. For status of a request, call: (888) 802-7001

Patient Information

Last Name: | First Name: | Middle: | DOB: ____/____/_____

Address: | City: | State: | Zip:

Daytime Phone: | Evening Phone: | Sex: ☐ Male ☐ Female

Insurance Information (*Attach copies of cards*)

Primary Insurance: | Secondary Insurance:

ID # | Group # | ID # | Group #

City: | State: | City: | State:

Physician Information

Name: | Specialty: | NPI:

Address: | City: | State: | Zip:

Phone #: | Secure Fax #: | Office Contact:

Primary Diagnosis

ICD-10 Code: ______________________________________

☐ Large B-cell lymphoma (LBCL) ☐ Other: _________________________

Prescription Information

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
Yescarta (axicabtagene ciloleucel)				

Clinical Information ***** *Please submit supporting clinical documentation* *****

☐ **INITIAL THERAPY** ☐ **CONTINUATION OF THERAPY;** Therapy start date: ______________________

1. Is Yescarta prescribed by or in consultation with an oncologist or hematologist? ☐ Yes ☐ No
2. Is disease refractory? ☐ Yes ☐ No
3. Has patient relapsed after ≥ 2 lines of systemic therapy that includes Rituxan (rituximab) and one anthracycline containing regimen (e.g., doxorubicin)? ☐ Yes: ____ ☐ No
4. Please document patient's absolute lymphocyte count (ALC): _________________/µL; date of testing: ________________
5. Does patient have active or primary central nervous system (CNS) disease? ☐ Yes ☐ No

Complete this section ONLY for indications <u>other</u> than large B-cell lymphoma:

6. Has patient tried and failed, or is contraindicated to, accepted standards of care? ☐ Yes ☐ No
   If yes, submit documentation and answer the following:
   a. Please list all previous therapies: ____
   b. Was patient adherent to previously tried therapies? ☐ Yes ☐ No ☐ No, patient intolerant to drug

Physician's Signature: ____ **Date:** __________________________ ☐ DAW

INFORMATION BELOW IS TO BE COMPLETE BY THE HEALTH PLAN/ EPS PA STAFF

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Authorization number:	**Decision Due Date:**
J-Code:	**Coverage:** ☐ State excludes ☐ COB (secondary)
Line of Business: ❑ Commercial ❑ Health Insurance Marketplace ❑ Medicaid ❑ Medicare (CY2019/20 Carved out)	**Benefit:** ❑ Medical ❑ Pharmacy

Criteria:
❑ Centene Policy
Date Policy last reviewed/approved by plan (we want to be sure we are using the version approved by your plan): ______________

❑ State Specific (please include policy)

Medicare only criteria for CY2019 and CY2020: Carved out to FFS (Fee for service) Medicare