HIGHMARK HEALTH OPTIONS

Updated: 05/2023
DMMA Approved: 07/2023

Request for Prior Authorization for Chimeric Antigen Receptor T cell (CAR-T) Immunotherapy
Website Form – www.highmarkhealthoptions.com
Submit request via: Fax - 1-855-476-4158

All requests for Chimeric Antigen Receptor T cell (CAR-T)* Immunotherapy require a Prior Authorization and will be screened for medical necessity and appropriateness using the criteria listed below.

Chimeric Antigen Receptor T cell (CAR-T) Immunotherapy Prior Authorization Criteria:

*CAR-T Immunotherapy medications include Kymriah (tisagenlecleucel), Yescarta (axicabtagene ciloleucel), Tecartus (brexucabtagene autoleucel), Breyanzi (lisocabtagene maraleucel), Abecma (idecabtagene vicleucel) and Carvykti (ciltacabtagene autoleucel). New products with this classification will require the same documentation.

For all requests for CAR-T Immunotherapy all of the following criteria must be met:

- Must have documentation of CD19 tumor expression (excluding Abecma and Carvykti)
- Must be prescribed by an Oncologist or Hematologist
- Must be given as a one-time, single administration treatment
- The member has received or will receive lymphodepleting chemotherapy within two weeks preceding infusion unless the member's WBC count is less than or equal to $1x10^9$/L within 1 week prior to infusion
- Documentation screening for HBV, HCV, and HIV in accordance with clinical guidelines before collection of cells for manufacturing must be performed due to risk of viral reactivation
- The requested dose and frequency is in accordance with FDA-approved labeling, nationally recognized compendia, and/or evidence-based practice guidelines
- Exclusion criteria:
    - Will not be used as first-line therapy;
    - Will not be used in combination with other chemotherapy agents;
    - Will not be given as repeat treatment in individuals who have received CAR-T treatment previously.
    - Will not be given if the member has primary central nervous system (CNS) lymphoma (excluding Abecma and Carvykti)

KYMRIAH™
Coverage may be provided with a diagnosis of B-cell acute lymphoblastic leukemia (ALL) and the following criteria is met:

- Member is up to 25 years of age
- Disease is considered refractory, or in second or later relapse, in *any* of the following scenarios:
    - Second or later bone marrow relapse;
    - Bone marrow relapse after allogeneic stem cell transplant;
    - Primary refractory or chemo-refractory after relapse;

    - Presence of > 5% blasts at screening
- For members with Ph+ ALL only:
    - Must provide documentation showing the member has tried and failed (which will be verified via pharmacy claims or submitted documentation) or had an intolerance or contraindication to the following:
        - At least two tyrosine kinase inhibitors (TKIs)
- **Duration of Approval:** 1 treatment

Coverage may be provided with a diagnosis of relapsed or refractory (r/r) large B-cell lymphoma and the following criteria is met:

- Member is 18 years of age and older
- The member is diagnosed with any of the following large B-cell lymphomas:
    - Diffuse large B-cell lymphoma (DLBCL) not otherwise specified,
    - High grade B-cell lymphoma
    - DLBCL arising from follicular lymphoma.
- Must provide documentation showing the member has tried and failed (which will be verified via pharmacy claims or submitted documentation) or had an intolerance or contraindication to the following:
    - Two or more lines of systemic therapy
- **Duration of Approval:** 1 treatment

Coverage may be provided with a diagnosis of relapsed or refractory (r/r) follicular lymphoma (FL) and the following criteria is met:

- Member is 18 years of age and older
- Must provide documentation showing the member has tried and failed (which will be verified via pharmacy claims or submitted documentation) or had an intolerance or contraindication to the following:
    - Two or more lines of systemic therapy
- **Duration of Approval:** 1 treatment

YESCARTA™

Coverage may be provided with a diagnosis of relapsed or refractory large B-cell lymphoma and the following criteria is met:

- Member is 18 years of age and older
- Members with large B-cell lymphoma that is refractory to first-line chemoimmunotherapy or that relapses within 12 months of first-line chemoimmunotherapy **OR**
- The member is diagnosed with any of the following large B-cell lymphomas:
    - Diffuse large B-cell lymphoma (DLBCL) not otherwise specified,
    - Primary mediastinal large B-cell lymphoma,
    - High grade B-cell lymphoma,
    - DLBCL arising from follicular lymphoma.
- Must provide documentation showing the member has tried and failed (which will be verified via pharmacy claims or submitted documentation) or had an intolerance or contraindication to the following:
    - Two or more lines of systemic therapy

- **Duration of Approval:** 1 treatment

Coverage may be provided with a diagnosis of relapsed or refractory follicular lymphoma (FL) and the following criteria is met:

- Member is 18 years of age and older
- Must provide documentation showing the member has tried and failed (which will be verified via pharmacy claims or submitted documentation) or had an intolerance or contraindication to the following:
    - Two or more lines of systemic therapy
- **Duration of Approval:** 1 treatment

TECARTUS™

Coverage may be provided with a diagnosis of relapsed or refractory mantle cell lymphoma and the following criteria is met:

- Member is 18 years of age and older
- Must provide documentation showing the member has tried and failed (which will be verified via pharmacy claims or submitted documentation) or had an intolerance or contraindication to all of the following:
    - Anthracycline or bendamustine containing chemotherapy
    - An anti-CD20 antibody
    - A Bruton tyrosine kinase inhibitor (BTKi; ibrutinib or acalabrutinib)
- **Duration of Approval:** 1 treatment

Coverage may be provided with a diagnosis of relapsed or refractory B-cell precursor acute lymphoblastic leukemia (ALL) and the following criteria is met:

- Member is 18 years of age and older
- Member has Philadelphia chromosome-negative disease that is relapsed or refractory as defined as one of the following:
    - Primary refractory disease
    - First relapse with remission of 12 months or less
    - Relapsed or refractory disease after at least 2 previous lines of systemic therapy
    - Relapsed or refractory disease after allogeneic stem cell transplant (allo-SCT)

For members with Ph+ ALL only:

- Must provide documentation showing the member has tried and failed (which will be verified via pharmacy claims or submitted documentation) or had an intolerance or contraindication to the following:
    - At least two tyrosine kinase inhibitors (TKIs)
- **Duration of Approval:** 1 treatment

BREYANZI®

Coverage may be provided with a diagnosis of relapsed or refractory large B-cell lymphoma and the following criteria is met:

- Member is 18 years of age and older
- The member is diagnosed with any of the following large B-cell lymphomas:

  - Diffuse large B-cell lymphoma (DLBCL) not otherwise specified (including DLBCL arising from indolent lymphoma),
  - Primary mediastinal large B-cell lymphoma,
  - High grade B-cell lymphoma,
  - Follicular lymphoma grade 3B
- Must provide documentation showing the member has tried and failed (which will be verified via pharmacy claims or submitted documentation) or had an intolerance or contraindication to **one** of the following:
  - refractory disease to first-line chemoimmunotherapy or relapse within 12 months of first-line chemoimmunotherapy
  - refractory disease to first-line chemoimmunotherapy or relapse after first-line chemoimmunotherapy and are not eligible for hematopoietic stem cell transplantation (HSCT) due to comorbidities or age
  - two or more lines of systemic therapy
- **Duration of Approval:** 1 treatment

ABECMA and CARVYKTI

Coverage may be provided with a diagnosis of relapsed or refractory multiple myeloma and the following criteria is met:

- Member is 18 years of age and older
- Must provide documentation showing the member has tried and failed (which will be verified via pharmacy claims or submitted documentation) or had an intolerance or contraindication to the following:
  - Four or more prior lines of therapy including:
    - an immunomodulatory agent
    - a proteasome inhibitor
    - an anti-CD38 monoclonal antibody
- **Duration of Approval:** 1 treatment

Coverage may be provided for any non-FDA labeled indication if it is determined that the use is a medically accepted indication supported by nationally recognized pharmacy compendia or peer-reviewed medical literature for treatment of the diagnosis(es) for which it is prescribed. These requests will be reviewed on a case by case basis to determine medical necessity.

Drugs are authorized in generic form unless the branded product is on the preferred drug list or the prescriber has indicated in writing that the branded product is medically necessary. If only the branded product is on the preferred drug list, the generic form will be considered non-preferred and shall not require the prescriber to indicate in writing that the branded product is medically necessary.

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CHIMERIC ANTIGEN RECEPTOR T-CELL (CAR-T) IMMUNOTHERAPY
PRIOR AUTHORIZATION FORM- Page 1 of 3

Please complete and fax all requested information below including any progress notes, laboratory test results, or chart documentation as applicable to Highmark Health Options Pharmacy Services. **FAX: (855) 476-4158**
If needed, you may call to speak to a Pharmacy Services Representative. **PHONE**: (844) 325-6251 Mon – Fri 8 am to 7 pm

PROVIDER INFORMATION

Requesting Provider:	NPI:
Provider Specialty:	Office Contact:
Office Address:	Office Phone:
	Office Fax:

MEMBER INFORMATION

Member Name:	DOB:	
Member ID:	Member weight:	Height:

REQUESTED DRUG INFORMATION

Medication:	Strength:	
Directions:	Quantity:	Refills:
Is the member currently receiving requested medication? ☐ Yes ☐ No	Date Medication Initiated:	

Is this medication being used for a chronic or long-term condition for which the medication may be necessary for the life of the patient? ☐ Yes ☐ No

Billing Information

This medication will be billed: ☐ at a pharmacy **OR** ☐ medically, JCODE:_____
Place of Service: ☐ Hospital ☐ Provider's office ☐ Member's home ☐ Other

Place of Service Information

Name:	NPI:
Address:	Phone:

MEDICAL HISTORY (Complete for ALL requests)

Diagnosis:	ICD Code:

For all CAR-T Immunotherapy:
Does the member have CD19 tumor expression documentation (excluding Abecma)? ☐ Yes ☐ No
Has the member received or will receive lymphodepleting chemotherapy within two weeks preceding the infusion?
☐ Yes ☐ No
Does the member have any of the following exclusions? Please mark if any apply. If NONE, leave blank.
☐ Medication will be used as first-line therapy
☐ Medication will be used in combination with other chemotherapy agents
☐ Medication will be given as repeat treatment in individuals who have received CAR-T treatment previously
☐ Medication will be given if the member has primary central nervous system (CNS) lymphoma (excluding Abecma)

Kymriah only:
Does the member have a diagnosis of B-cell acute lymphoblastic leukemia (ALL)? ☐ Yes ☐ No
Is the disease considered refractory, or in second or later relapse, in *any* of the following scenarios? Please mark which applies:
☐ Second or later bone marrow relapse;
☐ Bone marrow relapse after allogeneic stem cell transplant;
☐ Primary refractory or chemo-refractory after relapse
☐ Presence of > 5% blasts at screening

For members with Ph+ ALL only: Has the member tried and failed or had an intolerance or contraindication to at least two (2) tyrosine kinase inhibitors (TKIs)? ☐ Yes ☐ No

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CHIMERIC ANTIGEN RECEPTOR T-CELL (CAR-T) IMMUNOTHERAPY

PRIOR AUTHORIZATION FORM (CONTINUED) – PAGE 2 OF 3

Please complete and fax all requested information below including any progress notes, laboratory test results, or chart documentation as applicable to Highmark Health Options Pharmacy Services. **FAX: (855) 476-4158**
If needed, you may call to speak to a Pharmacy Services Representative. **PHONE**: (844) 325-6251 Mon – Fri 8 am to 7 pm

MEMBER INFORMATION

Member Name:	DOB:	
Member ID:	Member weight:	Height:

MEDICAL HISTORY (Complete for ALL requests)

Kymriah only:

Has the member been diagnosed with relapsed or refractory (r/r) large B-cell lymphoma? ☐ Yes ☐ No

Has the member been diagnosed with one of the following large B-cell lymphomas? Please mark which applies.

☐ Diffuse large B-cell lymphoma (DLBCL) not otherwise specified,
☐ High grade B-cell lymphoma
☐ DLBCL arising from follicular lymphoma.

Has the member tried and failed or had an intolerance or contraindication to two (2) or more lines of systemic therapy?
☐ Yes ☐ No

Does the member have a diagnosis of relapsed or refractory follicular lymphoma? ☐ Yes ☐ No

Has the member tried and failed or had an intolerance or contraindication to two (2) or more lines of systemic therapy?
☐ Yes ☐ No

Yescarta only:

Does the member have a diagnosis of relapsed or refractory large B-cell lymphoma? ☐ Yes ☐ No

Does the member have large B-cell lymphoma that is refractory to first-line chemoimmunotherapy or that relapses within 12 months of first-line chemoimmunotherapy? ☐ Yes ☐ No

Has the member been diagnosed with one of the following large B-cell lymphomas? Please mark which applies:

☐ Diffuse large B-cell lymphoma (DLBCL) not otherwise specified,
☐ Primary mediastinal large B-cell lymphoma,
☐ High grade B-cell lymphoma,
☐ DLBCL arising from follicular lymphoma

Has the member tried and failed or had an intolerance or contraindication to two (2) or more lines of systemic therapy?
☐ Yes ☐ No

OR

Does the member have a diagnosis of relapsed or refractory follicular lymphoma? ☐ Yes ☐ No

Has the member tried and failed or had an intolerance or contraindication to two (2) or more lines of systemic therapy?
☐ Yes ☐ No

Tecartus only:

Does the member have a diagnosis of relapsed or refractory mantle cell lymphoma? ☐ Yes ☐ No

Has the member tried and failed or had an intolerance or contraindication to **all** of the following? ☐ Yes ☐ No

- Anthracycline or bendamustine containing chemotherapy
- An anti-CD20 antibody
- A Bruton tyrosine kinase inhibitor (BTKi; ibrutinib or acalabrutinib)

Does the member have a diagnosis of relapsed or refractory B-cell precursor acute lymphoblastic leukemia (ALL)? ☐ Yes ☐ No

Does the member have Philadelphia chromosome-negative disease that is relapsed or refractory as defined as one of the following? Please mark which applies:

- Primary refractory disease
- First relapse with remission of 12 months or less
- Relapsed or refractory disease after at least 2 previous lines of systemic therapy
- Relapsed or refractory disease after allogeneic stem cell transplant (allo-SCT)

For members with Ph+ ALL only: Has the member tried and failed or had an intolerance or contraindication to at least two (2) tyrosine kinase inhibitors (TKIs)? ☐ Yes ☐ No

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CHIMERIC ANTIGEN RECEPTOR T-CELL (CAR-T) IMMUNOTHERAPY

PRIOR AUTHORIZATION FORM (CONTINUED) – PAGE 3 of 3

Please complete and fax all requested information below including any progress notes, laboratory test results, or chart documentation as applicable to Highmark Health Options Pharmacy Services. **FAX: (855) 476-4158**

If needed, you may call to speak to a Pharmacy Services Representative. **PHONE**: (844) 325-6251 Mon – Fri 8 am to 7 pm

MEMBER INFORMATION

Member Name:	DOB:	
Member ID:	Member weight:	Height:

Breyanzi only:

Does the member have a diagnosis of relapsed or refractory large B-cell lymphoma? ☐ Yes ☐ No

Has the member been diagnosed with one of the following large B-cell lymphomas? Please mark which applies:

☐ Diffuse large B-cell lymphoma (DLBCL) not otherwise specified (including DLBCL arising from indolent lymphoma)
☐ Primary mediastinal large B-cell lymphoma
☐ High grade B-cell lymphoma
☐ Follicular lymphoma grade 3B

Has the member tried and failed or had an intolerance or contraindication to one of the following? Please mark which applies:

☐ refractory disease to first-line chemoimmunotherapy or relapse within 12 months of first-line chemoimmunotherapy
☐ refractory disease to first-line chemoimmunotherapy or relapse after first-line chemoimmunotherapy and are not eligible for hematopoietic stem cell transplantation (HSCT) due to comorbidities or age
☐ two or more lines of systemic therapy

Abecma and Carvykti only:

Does the member have a diagnosis of relapsed or refractory multiple myeloma?

Has the member tried and failed or had an intolerance or contraindication to four or more prior lines of therapy including: an immunomodulatory agent, a proteasome inhibitor an anti-CD38 monoclonal antibody? ☐ Yes ☐ No

CURRENT or PREVIOUS THERAPY

Medication Name	Strength/ Frequency	Dates of Therapy	Status (Discontinued & Why/Current)

SUPPORTING INFORMATION or CLINICAL RATIONALE

Prescribing Provider Signature	Date