Commonwealth of Massachusetts
MassHealth Drug Utilization Review Program
P.O. Box 2586, Worcester, MA 01613-2586
Fax: (877) 208-7428 **Phone:** (800) 745-7318

Print Clear

Chimeric Antigen Receptor (CAR)-T Immunotherapies Prior Authorization Request

MassHealth reviews requests for prior authorization (PA) on the basis of medical necessity only. If MassHealth approves the request, payment is still subject to all general conditions of MassHealth, including current member eligibility, other insurance, and program restrictions. MassHealth will notify the requesting provider and member of its decision. Keep a copy of this form for your records. If faxing this form, please use black ink.

Additional information about these agents, including PA requirements and preferred products, can be found within the MassHealth Drug List at **www.mass.gov/druglist.**

Member information

Last name _____ First name _____ MI _____

MassHealth member ID # _____ Date of birth _____

Gender (Check one.) ☐ F ☐ M Member's place of residence ☐ home ☐ nursing facility

Medication information

Medication requested

☐ Abecma (idecabtagene vicleucel)^
☐ Breyanzi (lisocabtagene maraleucel)^
☐ Carvykti (ciltacabtagene autoleucel)^
☐ Kymriah (tisagenlecleucel)^
☐ Tecartus (brexucabtagene autoleucel)^
☐ Yescarta (axicabtagene ciloleucel)^

^*This drug is available through the health care professional who administers the drug. MassHealth does not pay for this drug to be dispensed through a retail pharmacy.*

Dose, frequency, and duration of medication requested

_____

Indication (Check all that apply.)

‡ Abecma and Carvykti requests only ††Breyanzi requests only *Kymriah requests only †Tecartus requests only **Yescarta requests only

☐ B-cell precursor acute lymphoblastic leukemia (ALL) that is refractory or in second or later relapse*
☐ Large B-cell lymphoma that is refractory to first-line chemoimmunotherapy or that relapses within 12 months of first-line chemoimmunotherapy**
☐ Relapsed or refractory follicular lymphoma (FL) after two or more lines of systemic therapy **
☐ Relapsed or refractory large B-cell lymphoma after two or more lines of systemic therapy, including diffuse large B-cell lymphoma (DLBCL) not otherwise specified (NOS), high grade B-cell lymphoma, and DLBCL arising from FL*
☐ Relapsed or refractory large B-cell lymphoma after two or more lines of systemic therapy, including DLBCL NOS, primary mediastinal large B-cell lymphoma, high grade B-cell lymphoma, and DLBCL arising from FL**
☐ Relapsed or refractory B-cell precursor acute lymphoblastic leukemia (ALL) †
☐ Relapsed or refractory mantle cell lymphoma (MCL) †
☐ Relapsed or refractory multiple myeloma after four or more prior lines of therapy, including an immunomodulatory agent, a proteasome inhibitor, and an anti-CD38 monoclonal antibody ‡

☐ Relapsed or refractory large B-cell lymphoma after two or more lines of systemic therapy, including DLBCL NOS (including DLBCL arising from indolent lymphoma), high-grade B-cell lymphoma, primary mediastinal large B-cell lymphoma, and FL grade 3B††

Please indicate prescriber specialty below.
☐ Hematology ☐ Oncology ☐ Other _____

Section I. Please complete for all requests.

1. Member's current weight _____ Date _____
2. Please provide anticipated dates for the following as applicable.
   Treatment date _____ Leukapheresis _____ Admission _____ Infusion _____ Discharge _____
3. Please provide the infusion setting. ☐ Inpatient ☐ Outpatient
4. Will the infusion take place in a health care facility that has been certified pursuant to the Risk Evaluation and Mitigation Strategy (REMS) program specific to the treatment being provided? ☐ Yes ☐ No
5. Please list any other prior trials including the drug names, dates/duration of use, and outcomes below. Please note, Abecma and Carvykti are FDA-approved for use after four or more lines of therapy, including an immunomodulatory agent, a proteasome inhibitor, and an anti-CD38 monoclonal antibody.*
   Drug _____ Dates/duration _____ ☐ Adverse reaction ☐ Inadequate response ☐ Other
   Briefly describe details of adverse reaction, inadequate response, or other.
   _____
   Drug _____ Dates/duration _____ ☐ Adverse reaction ☐ Inadequate response ☐ Other
   Briefly describe details of adverse reaction, inadequate response, or other.
   _____
   Drug _____ Dates/duration _____ ☐ Adverse reaction ☐ Inadequate response ☐ Other
   Briefly describe details of adverse reaction, inadequate response, or other.
   _____
   Drug _____ Dates/duration _____ ☐ Adverse reaction ☐ Inadequate response ☐ Other
   Briefly describe details of adverse reaction, inadequate response, or other.
   _____
6. Outreach for both short- and long-term monitoring for efficacy and durability of response will be conducted by MassHealth. The applicable information [including but not limited to: medical records, dates of procedures, infusions, and admissions; adverse reactions experienced; agents used to treat adverse reactions; response to therapy (e.g. complete blood count, bone marrow blasts, peripheral blood blasts, platelets, absolute neutrophil counts)] will be provided to MassHealth upon request. ☐ Yes ☐ No

Section II. Please also complete for Kymriah requests for a diagnosis of B-cell precursor acute lymphoblastic leukemia (ALL) that is refractory or in second or later relapse.

1. Please indicate Philadelphia chromosome type. ☐ Positive ☐ Negative
   If positive, has the member failed two kinase inhibitors? ☐ Yes. Please provide details below.* ☐ No
   Drug _____ Dates/duration _____ Outcome _____'
   Drug _____ Dates/duration _____ Outcome _____
2. Does the member have refractory disease? ☐ Yes ☐ No
3. Please provide the number of relapses. _____

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Section III. Please also complete for Tecartus requests for a diagnosis of relapsed or refractory B-cell precursor acute lymphoblastic leukemia (ALL).

1. Please indicate Philadelphia chromosome type. ☐ Positive ☐ Negative
   If positive, has the member failed one tyrosine kinase inhibitor? ☐ Yes. Please provide details below.* ☐ No
   Drug _____ Dates/duration _____ Outcome _____
2. Does the member have primary refractory disease? ☐ Yes ☐ No
3. Please provide the number of relapses. _____ Dates/duration _____
4. Did the member receive an allogeneic stem cell transplant? ☐ Yes ☐ No Date _____

Section IV. Please complete for all requests for non-preferred drug products if one or more preferred drug products have been designated for this class of drugs.

If one or more preferred drug products have been designated for this class of drugs, and if you are requesting PA for a non-preferred drug product, please provide medical necessity for prescribing the non-preferred drug product rather than the preferred drug product.

_____

_____

**Attach a letter with additional information regarding medication trials as applicable.*

Prescriber information

Last name* _____ First name* _____ MI _____

NPI* _____ Individual MH Provider ID _____

DEA No. _____ Office Contact Name _____

Address _____ City _____ State _____ Zip _____

E-mail address _____

Telephone No.* _____ Fax No.* _____

* *Required*

Prescribing provider's attestation, signature, and date

I certify under the pains and penalties of perjury that I am the prescribing provider identified in the Prescriber information section of this form. Any attached statement on my letterhead has been reviewed and signed by me. I certify that the medical necessity information (per 130 CMR 450.204) on this form is true, accurate, and complete, to the best of my knowledge. I understand that I may be subject to civil penalties or criminal prosecution for any falsification, omission, or concealment of any material fact contained herein.

Prescribing provider's signature (Signature and date stamps, or the signature of anyone other than the provider, are not acceptable.)

Signature required _____

Printed name of prescribing provider _____ Date _____