SENTARA COMMUNITY PLAN
(MEDICAID)

MEDICAL PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-844-305-2331**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If information provided is not complete, correct, or legible, authorization can be delayed**.

Drug Requested: Breyanzi® (liscoabtagene maraleucel) **IV (Q2054)**

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member Sentara #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

DEA OR NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight: _____ **Date:** _____

❑ Standard Review. In checking this box, the timeframe does not jeopardize the life or health of the member or the member's ability to regain maximum function and would not subject the member to severe pain.

Quantity Limit:

- **Pharmacy Benefit** – N/A
- **Medical Benefit** – Max Units (per dose and over time): 1 infusion of Breyanzi®® only
  - NDC: Breyazni® suspension for intravenous infusion: 73153-0900-08

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

Approval Criteria – Coverage cannot be renewed

❑ Member is 18 years of age or older

❑ Member does **NOT** have a clinically significant active systemic infection or inflammatory disorder

❑ Member has **NOT** received live vaccines within 6 weeks prior to the start of lymphodepleting chemotherapy, during treatment, and will not receive live vaccines until immune recovery following treatment

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- ❑ Member has been screened for hepatitis B virus (HBV), hepatitis C virus (HCV), and human immunodeficiency virus (HIV) in accordance with clinical guidelines prior to collection of cells (leukapheresis)
- ❑ Prophylaxis for infection has been followed according to local guidelines
- ❑ Healthcare facility has enrolled in the BREYANZI REMS Program and training has been given to providers on the management of cytokine release syndrome (CRS) and neurological toxicities
- ❑ Member has **NOT** received prior CAR-T therapy
- ❑ Member has **NOT** received prior anti-CD19 therapy, (e.g., tafasitamab) OR member previously received anti-CD19 therapy and re-biopsy indicates CD-19 positive disease
- ❑ Medication will be used as single agent therapy (not applicable to lymphodepleting or additional chemotherapy while awaiting manufacture)
- ❑ Member does **NOT** have primary central nervous system lymphoma
- ❑ Member has an ECOG performance status of ≤ 2
- ❑ Member has a diagnosis of diffuse large B cell lymphoma (DLBCL), not otherwise specified, including DLBCL arising from indolent lymphoma; high-grade B-cell lymphoma; primary mediastinal B-cell lymphoma (PMBCL); follicular lymphoma Grade 3B
- ❑ Member must have **ONE** of the following:
  - ❑ Refractory disease to first-line chemoimmunotherapy or relapse within 12 months of first-line chemoimmunotherapy (e.g., rituximab with dexamethasone, cytarabine, and cisplatin)
  - ❑ Refractory disease to first-line chemoimmunotherapy or relapse after first-line chemoimmunotherapy (e.g., rituximab with dexamethasone, cytarabine, and cisplatin) and are **NOT** eligible for hematopoietic stem cell transplantation (HSCT) due to comorbidities or age
  - ❑ Relapsed or refractory disease after two or more lines of systemic therapy with anthracycline and CD20-targeted agent

Reauthorization Criteria – Coverage cannot be renewed

Medication being provided by (check box below that applies):

- ❑ **Location/site of drug administration:** _____

  NPI or DEA # of administering location: _____

OR

- ❑ **Specialty Pharmacy - PropriumRx**

For urgent reviews: Practitioner should call Sentara Health Pre-Authorization Department if they believe a standard review would subject the member to adverse health consequences. Sentara Health's definition of urgent is a lack of treatment that could seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

*****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.*****

****Previous therapies will be verified through pharmacy paid claims or submitted chart notes.****