MASSACHUSETTS

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CAR T-Cell Therapy Services for the Treatment of Diffuse Large B-cell Lymphoma (axicabtagene ciloleucel) Prior Authorization Request Form #924

Medical Policy #066 Chimeric Antigen Receptor Therapy for Hematologic Malignancies

CLINICAL DOCUMENTATION

- Clinical documentation that supports the medical necessity criteria for CAR T-Cell Therapy Services for the Treatment of Diffuse Large B-cell Lymphoma (axicabtagene ciloleucel) must be submitted.
- If the patient does not meet all the criteria listed below, please submit a letter of medical necessity with a request for Clinical Exception (Individual Consideration) explaining why an exception is justified.

Requesting Prior Authorization Using Authorization Manager

Providers will need to use Authorization Manager to submit initial authorization requests for services. Authorization Manager, available 24/7, is the quickest way to review authorization requirements, request authorizations, submit clinical documentation, check existing case status, and view/print the decision letter. For commercial members, the requests must meet medical policy guidelines.

To ensure the request is processed accurately and quickly:

- Enter the facility's NPI or provider ID for where services are being performed.
- Enter the appropriate surgeon's NPI or provider ID as the servicing provider, *not* the billing group.

Authorization Manager Resources

Refer to our Authorization Manager page for tips, guides, and video demonstrations.

Complete Prior Authorization Request Form for CAR T-Cell Therapy Services for Treatment of Diffuse Large B-cell Lymphoma (924) using Authorization Manager.

For out of network providers: Requests should still be faxed to 888-973-0726.

Patient Information	
Patient Name:	Today's Date:
BCBSMA ID#:	Date of Treatment:
Date of Birth:	Place of Service: Outpatient ❒ Inpatient ❒

Physician Information	**Facility Information**
Name:	Name:
Address:	Address:
Phone #:	Phone #:
Fax#:	Fax#:
NPI#:	NPI#:

Please check off if the patient is enrolled in a Clinical Trial:	
Clinical Trial #	❒

Please check off if the patient has ONE of the following histologically confirmed diagnoses and HAS RELAPSED or is REFRACTORY [a]:	
Histologically confirmed diagnosis of: • Diffuse large B-cell lymphoma not otherwise specified (including diffuse large B-cell lymphoma arising from indolent lymphoma), refractory to first line chemoimmunotherapy OR relapsed within 12 months of completing first line chemoimmunotherapy **OR**	❒
• High-grade B-cell lymphoma, **OR**	❒
• Primary mediastinal large B-cell lymphoma, **OR**	❒
• Follicular lymphoma grade 3B	❒

[b] Tisagenlecleucel intravenous infusion is considered investigational for the treatment of relapsed or refractory primary mediastinal large B-cell lymphoma.

Please check off that the patient meets ALL the following criteria:	
1. Meet any one of the following: a. Histologically confirmed diagnosis of large B-cell lymphoma that is considered refractory to first line chemoimmunotherapy, or relapsed within 12 months, following first-line chemoimmunotherapy that included an anti-CD20 monoclonal antibody and anthracycline-containing regimen; **OR** b. Histologically confirmed diagnosis of diffuse large B-cell lymphoma not otherwise specified, primary mediastinal large B-cell lymphoma, high grade B-cell lymphoma, or diffuse B-cell lymphoma arising from follicular lymphoma, and all of the following: i. Relapsed or refractory disease defined as progression after ≥2 lines of systemic therapy including anti-CD20 monoclonal antibody for CD20-positive tumor and anthracycline-containing chemotherapy. ii. When the individual has histological transformation of follicular lymphoma or nodal marginal zone lymphoma to diffuse large B-cell lymphoma: prior chemotherapy for follicular lymphoma and ≥2 chemo-immunotherapy regimens for the transformed disease; **AND**	❒ ❒
2. At least 18 years of age at the time of infusion; **AND**	❒
3. Have adequate organ and bone marrow function as determined by the treating oncologist/hematologist; **AND**	❒
4. Have not received prior CD19-directed chimeric antigen receptor T-cell therapy treatment, any other cell therapy, or any gene therapy or are being considered for treatment with any other cell therapy or any gene therapy; **AND**	❒
5. Do not have primary central nervous system lymphoma.	❒

[c] Relapsed or refractory disease is defined as progression after 2 or more lines of systemic therapy (which may or may not include therapy supported by autologous cell transplant).

Please check off if the facility is part of Risk Evaluation and Mitigation Strategy (REMS)	
The facility delivering the therapy is certified by Kite Pharma that it has an adequate REMS protocol (Risk Evaluation and Mitigation Strategy) to address a cytokine release syndrome and neurotoxicity	❒

Note: Other adoptive immunotherapy, using adoptive cellular therapy for the administration of cytotoxic T-lymphocytes, cytokine-induced killer cells, tumor-infiltrating lymphocytes, antigen-loaded autologous dendritic cells, or genetically-engineered T-cells is considered **INVESTIGATIONAL**.

CPT CODES/ HCPCS CODES/ ICD CODES

HCPCS codes:	Code Description	
C9399	Unclassified drugs or biologicals	❒
J3490	Unclassified drugs	❒
J3590	Unclassified biologics	❒
J9999	Not otherwise classified, antineoplastic drugs	❒
Q2041	Axicabtagene Ciloleucel, up to 200 Million Autologous Anti-CD19 CAR T Cells, Including Leukapheresis And Dose Preparation Procedures, Per Infusion	❒
S2107	Adoptive immunotherapy, i.e., development of specific anti-tumor reactivity (e.g., tumor infiltrating lymphocyte therapy) per course of treatment	❒

Providers should enter the relevant diagnosis code(s) below:

Code	Description	
		❒
		❒

Providers should enter other relevant code(s) below:

Code	Description	
		❒
		❒