MASSACHUSETTS

Blue Cross Blue Shield of Massachusetts is an Independent Licensee of the Blue Cross and Blue Shield Association

CAR T-Cell Therapy Services for Mantle Cell Lymphoma (Brexucabtagene Autoleucel) Prior Authorization Request Form #940

Medical Policy #066 Chimeric Antigen Receptor Therapy for Hematologic Malignancies

Please use this form to assist in identifying members who meet Blue Cross Blue Shield of Massachusetts' (BCBSMA's) medical necessity criteria for CAR T-Cell Therapy Services for Mantle Cell Lymphoma (Brexucabtagene Autoleucel). For members who do not meet the criteria, submit a letter of medical necessity with a request for Clinical Exception (Individual Consideration). Once completed, fax to**:**

Once completed, please fax to: 888-973-0726

CLINICAL DOCUMENTATION
Copies of clinical documentation that supports the medical necessity criteria for CAR T-Cell Therapy Services for Mantle Cell Lymphoma (Brexucabtagene Autoleucel) must be submitted with this form. **If the patient does not meet all the criteria listed below, please submit a letter of medical necessity explaining why an exception is justified.**

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 the following diagnosis and HAS RELAPSED[d] or is REFRACTORY[d]:	
Histologically confirmed diagnosis of mantle cell lymphoma	❒

[d] Relapsed or refractory disease is defined as disease progression after last regimen or failure to achieve a partial remission or complete remission to the last regimen

Please check off that the patient meets ALL the following criteria:	
Adult (age ≥18) at the time of infusion	❒
Received adequate prior therapy including **ALL** of the following:	❒

• Chemotherapy, **AND** • anti-CD20 antibody, **OR** • Bruton tyrosine kinase inhibitor (example ibrutinib or acalabrutinib)	
Has adequate organ and bone marrow function as determined by the treating oncologist/hematologist, **AND**	❒
Has not received prior FDA approved, CD19-directed, chimeric antigen receptor T therapy	❒

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	❒
Q2053	Brexucabtagene autoleucel, up to 200 million autologous anti-cd19 car positive viable t cells, including leukapheresis and dose preparation procedures, per therapeutic dose	❒
XW23346	Transfusion of Brexucabtagene Autoleucel Immunotherapy into Peripheral Vein, Percutaneous Approach, New Technology Group 6	❒

Providers should enter the <u>relevant diagnosis code(s)</u> below:

Code	Description	
		❒
		❒

Providers should enter <u>other relevant code(s)</u> below:

Code	Description	
		❒
		❒