



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 Non-Hodgkin Lymphoma (Lisocabtagene Maraleucel) Prior Authorization Request Form #941

## Medical Policy #066 Chimeric Antigen Receptor Therapy for Leukemia and Lymphoma

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 Non-Hodgkin Lymphoma (Lisocabtagene Maraleucel). 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 Non-Hodgkin Lymphoma (Lisocabtagene Maraleucel) 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 <input type="checkbox"/> Inpatient <input type="checkbox"/>

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 #	<input type="checkbox"/>

Please check off if the patient has the following diagnosis and <b>HAS RELAPSED<sup>c</sup></b> or is <b>REFRACTORY<sup>c</sup></b> :	
Histologically confirmed diagnosis of:  Diffuse large B-cell lymphoma not otherwise specified (including diffuse large B-cell lymphoma arising from indolent lymphoma)	<input type="checkbox"/>
High-grade B-cell lymphoma, <b>OR</b>	<input type="checkbox"/>
Primary mediastinal large B-cell lymphoma, <b>OR</b>	<input type="checkbox"/>

Follicular lymphoma grade 3B.	<input type="checkbox"/>
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° 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).

<b>Please check off that the patient meets ALL the following criteria:</b>	
Adult (age ≥18) at the time of infusion	<input type="checkbox"/>
Received adequate prior therapy including <b>ALL</b> of the following: <ul style="list-style-type: none"> <li>• Anti-CD20 monoclonal antibody for CD20-positive tumor</li> <li>• Anthracycline-containing chemotherapy regimen</li> <li>• For subjects with transformed follicular lymphoma, prior chemotherapy for follicular lymphoma <b>AND</b> subsequently have chemo-refractory disease after transformation to diffuse large B-cell lymphoma.</li> </ul>	<input type="checkbox"/>
Has adequate organ and bone marrow function as determined by the treating oncologist/hematologist	<input type="checkbox"/>
Has not received prior FDA approved, CD19-directed, chimeric antigen receptor T therapy, <b>AND</b>	<input type="checkbox"/>
Do not have primary central nervous system lymphoma	<input type="checkbox"/>

**CPT CODES/ HCPCS CODES/ ICD CODES**

<b>HCPCS codes:</b>	<b>Code Description</b>	
C9076	Lisocabtagene maraleucel, up to 110 million autologous anti-cd19 car-positive viable t cells, including leukapheresis and dose preparation procedures, per therapeutic dose	<input type="checkbox"/>
C9399	Unclassified drugs or biologicals	<input type="checkbox"/>
J3490	Unclassified drugs	<input type="checkbox"/>
J3590	Unclassified biologics	<input type="checkbox"/>
J9999	Not otherwise classified, antineoplastic drugs	<input type="checkbox"/>

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

<b>Code</b>	<b>Description</b>	
		<input type="checkbox"/>
		<input type="checkbox"/>

Providers should enter other relevant code(s) below:

<b>Code</b>	<b>Description</b>	
		<input type="checkbox"/>
		<input type="checkbox"/>