MASSACHUSETTS

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CAR T-Cell Therapy Services for Follicular Lymphoma (Axicabtagene Ciloleucel) Prior Authorization Request Form #944

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

CLINICAL DOCUMENTATION

- Clinical documentation that supports the medical necessity criteria for CAR T-Cell Therapy Services for Follicular 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 Follicular Lymphoma (Axicabtagene Ciloleucel) (944) 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 the following diagnosis and HAS RELAPSED[c] or is REFRACTORY[c]:	
Histologically confirmed diagnosis of: Follicular 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 that the patient meets ALL the following criteria:	
1. Histologically confirmed diagnosis of follicular lymphoma; **AND**	❒
2. Relapsed or refractory disease defined as progression after ≥2 lines of systemic therapy for follicular lymphoma; **AND**	❒
3. At least 18 years of age at the time of infusion; **AND**	❒
4. Have adequate organ and bone marrow function as determined by the treating oncologist/hematologist; **AND**	❒
5. 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**	❒
6. Do not have primary central nervous system lymphoma.	❒

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	❒

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

Code	**Description**	
		❒
		❒

Providers should enter other relevant code(s) below:

Code	**Description**	
		❒
		❒