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

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 Follicular Lymphoma (Axicabtagene Ciloleucel) 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[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:	
Adult (age ≥18) at the time of infusion	❒
Has received two or more lines of systemic therapy for treatment of follicular lymphoma	❒

Has adequate organ and bone marrow function as determined by the treating oncologist/hematologist	❒
Has not received prior FDA approved, CD19-directed, chimeric antigen receptor T therapy, **AND**	❒
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	
		❒
		❒