MASSACHUSETTS

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CAR T-Cell Therapy Services for B-cell Acute Lymphoblastic Leukemia (Brexucabtagene Autoleucel) Prior Authorization Request Form #945

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 B-cell Acute Lymphoblastic Leukemia (Brexucabtagene Autoleucel) 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 CAR T-Cell Therapy Services for B-cell Acute Lymphoblastic Leukemia (Brexucabtagene Autoleucel) Prior Authorization Request Form (945) 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[a] or is REFRACTORY[b] :	
Confirmed diagnosis of CD19-positive B-cell acute lymphoblastic leukemia with morphologic bone marrow tumor involvement (≥5% lymphoblasts)	❒

[a] Relapsed disease describes the reappearance of leukemia cells in the bone marrow or peripheral blood after the attainment of a complete remission with chemotherapy and/or allogeneic cell transplant.
[b] Refractory (resistant) disease is defined as those patients who fail to obtain complete response with induction therapy, ie, failure to eradicate all detectable leukemia cells (<5% blasts) from the bone marrow and blood with subsequent restoration of normal hematopoiesis (>25% marrow cellularity and normal peripheral blood counts).

Please check off that the patient meets ALL the following criteria:	
1. Confirmed diagnosis of CD19-positive B-cell acute lymphoblastic leukemia with morphologic bone marrow tumor involvement (≥5% lymphoblasts); **AND**	❒
2. Meet any one of the following: a. Relapsed diseasea defined as the reappearance of leukemia cells in the bone marrow or peripheral blood after the attainment of a complete remission with chemotherapy and/or allogeneic cell transplant; OR b. Refractory diseaseb defined as failure to obtain complete response with induction therapy (ie, failure to eradicate all detectable leukemia cells [<5% blasts] from the bone marrow and blood with subsequent restoration of normal hematopoiesis [>25% marrow cellularity and normal peripheral blood counts]).	❒
3. When Philadelphia chromosome-positive: failure of tyrosine kinase inhibitors; **AND**	❒
4. At least 18 years of age at the time of infusion; **AND**	❒
5. Have not received prior CD19-directed chimeric antigen receptor T-cell 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. Have adequate organ function with no significant deterioration in organ function expected within 4 weeks after apheresis; **AND**	❒
7. Do not have any of the following: a. Burkitt lymphoma. b. Active hepatitis B, C, or any uncontrolled infection. c. Grade 2 to 4 graft-versus-host disease. d. Concomitant genetic syndrome associated with bone marrow failure with the exception of Down syndrome. e. Received allogeneic cellular therapy, such as donor lymphocyte infusion, within 6 weeks prior to brexucabtagene autoleucel infusion. f. Active central nervous system acute lymphoblastic leukemia (ie, white blood cell count ≥5 cells/μL in cerebrospinal fluid with presence of lymphoblasts).	❒

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 relevant diagnosis code(s) below:

Code	Description

Providers should enter other relevant code(s) below:

Code	Description