KAISER PERMANENTE

10/3/2022

PHARMACY REVIEW SERVICES
PHONE: (206) 901-4700
FAX: (800) 377-8853

PATIENT:			
DOB:		**MEMBER #:**	
PRESCRIBER:		**ALT #:**	
ADMIN LOCATION:		**DX CODE (S):**	

Breyanzi (lisocabtagene maraleucel)
Office Administered Prior Authorization Drug Request Form

Please provide any or all clinical chart notes along with this page

Diagnosis:

Diffuse Large B-Cell Lymphoma (DLBCL)

☐ YES ☐ NO (If YES, check all criteria that apply below)

- ☐ YES ☐ NO Patient has primary refractory or relapse disease within one year

Relapsed or Refractory Follicular Lymphoma

☐ YES ☐ NO (If YES, check all criteria that apply below)

- ☐ YES ☐ NO Patient has histologic transformation
- ☐ YES ☐ NO Patient has either late relapse or early relapse for patients who are considered transplant ineligible
- ☐ YES ☐ NO Patient has a good performance status ECOG 0-1

Primary Mediastinal Large B-Cell Lymphoma (PMBCL)

☐ YES ☐ NO (If YES, check all criteria that apply below)

- ☐ YES ☐ NO Prescribed by an oncologist with expertise in malignant hematology
- ☐ YES ☐ NO Patient is 18 years or older
- ☐ YES ☐ NO Patient has chemotherapy-refractory disease defined as:
  - ☐ Refractory to two or more lines of chemotherapy with less than partial response to last line of therapy
  OR
  - ☐ Refractory post-autologous hematopoietic stem cell transplantation (HSCT)

Required Documentation (please include specific values as applicable):

☐ YES ☐ NO Adequate prior therapy including at a minimum:

- ☐ Anti-CD20 monoclonal antibody unless tumor is CD20-negative and an anthracycline containing chemotherapy regimen

Authorization duration: limited to a one-time (single infusion) treatment