KAISER PERMANENTE

10/3/2022

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

| PATIENT: | | | |
|---|---|---|---|
| DOB: | | MEMBER #: | |
| PRESCRIBER: | | ALT #: | |
| ADMIN | | DX CODE (S): | |

## Yescarta (axicabtagene ciloleucel)

**Office-Administered Drug Prior Authorization Request Form**

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

**Diagnosis:**

### Diffuse Large B-Cell Lymphoma (DLBCL) or Follicular Lymphoma that has been transformed to 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 good performance status ECOG 0-1

### Primary Mediastinal Large B-Cell Lymphoma (PBMCL)

☐ 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

Does patient have any of the following exclusion criteria listed below:

☐ YES ☐ NO Has patient received prior CAR-T therapy or other genetically modified T cell therapy

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