PA24
Yescarta™ (axicabtagene ciloleucel) or
Kymriah® (tisagenlecleucel)

Executive Office of Health & Human Services

MEDICAID FEE FOR SERVICE (FFS) PRIOR AUTHORIZATION REQUEST FORM
Gainwell Technologies ATTN: PHARMACIST
FAX (401) 784-3889 ▪ PH (401) 784-8100

PATIENT NAME: _____DOB: ____ /_____/_____ ID NUMBER: _____

PRESCRIBER NAME: _____PRESCRIBER NPI #: _____

OFFICE PHONE NUMBER: ( ) _____ OFFICE FAX NUMBER: ( ) _____

RENDERING PROVIDER NAME: _____ RENDERING PROVIDER NPI #: _____

SUPPORTING DOCUMENTATION SHOULD BE MAINTAINED WITH THE PATIENT RECORD. ADDITIONAL DOCUMENTATION SHOULD BE SUBMITTED ONLY IF REQUESTED BY RI EOHHS.

CLINICAL INFORMATION:

a. CAR T REQUESTED (SELECT ONE): _____ KYMRIAH® (tisagenlecleucel) Q2040 **or** _____YESCARTA™ (axicabtagene ciloleucel) Q2041

b. REQUESTED DATE OF TREATMENT: _____

c. DIAGNOSIS: _____ICD 10 CODE:_____

d. CURRENT CLINICAL STATUS:

_____

_____

_____

e. HAS THE PATIENT HAD PRIOR THERAPY WITH GENE THERAPY: _____YES _____ NO

f. HAS THE PATIENT FAILED AT LEAST TWO LINES OF THERAPY? _____YES _____ NO

g. IS THE PATIENT'S DISEASE REFRACTORY, OR HAS THE PATIENT RELAPSED AFTER 2 OR MORE LINES OF THERAPY? _____YES _____ NO

h. DOES THE PATIENT HAVE PRIOR CENTRAL NERVOUS SYSTEM LYMPHOMA: _____YES _____ NO

i. DOES THE PATIENT HAVE ADEQUATE BONE MARROW, CARDIAC, PULMONARY AND OTHER ORGAN FUNCTION: _____YES _____ NO

j. DOES THE PATIENT HAVE A HISTORY OF ALLOGENIC STEM CELL TRANSPLANTATION: _____YES _____ NO

   i. IF YES, IS THERE ANY INDICATION OF GRAFT VS HOST DISEASE: _____YES _____ NO

k. IS RENDERING PROVIDER/FACILITY CERTIFIED UNDER KYMRIAH® OR YESCARTA™ REMS SYSTEM PROGRAM: _____YES _____ NO

PRESCRIBER ATTESTATION AND SIGNATURE _____**DATE** _____

BY SIGNATURE, THE PRESCRIBER CONFIRMS S/HE IS AUTHORIZED TO PRESCRIBE THIS MEDICATION BY RI MEDICAID AND THE CRITERIA INFORMATION ABOVE IS ACCURATE, VERIFIABLE BY CLIENT RECORDS AND AVAILABLE FOR REVIEW UPON REQUEST.

FOR STATE USE ONLY:

APPROVAL: _____ YES ____NO PRIOR AUTHORIZATION #: _____ EFFECTIVE DATES: FROM: _____ TO _____