Kymriah® (intravenous tisagenlecleucel)
Prior Authorization Form
Fax: 1-844-639-7906
Pharmacy Dept. Phone: 1-401-427-8200

Please complete the form by providing all of the following information. Failure to fill out this form in its entirety may delay the review process. To review the Clinical Medical Policies, please visit our website at https://www.nhpri.org/Providers/ClinicalMedicalPolicies.aspx

MEMBER INFORMATION		
Member's Name:	Member's ID Number:	Member's DOB:
REQUESTING PROVIDER INFORMATION		
Provider's Name:	Provider's Phone #:	Provider's Fax #:
Provider's NPI #:	Provider's Contact Name and Phone #:	

SERVICING PROVIDER INFORMATION (Must be filled out appropriately to ensure claim adjudication)

HOW WILL MEDICATION BE OBTAINED:

□ Drop Ship from Specialty Pharmacy: _____ NPI: _____

□ If Buy and bill, please provide the following information for the servicing provider: □ Same as Requesting Provider
Servicing Provider/Facility Name: _____
Servicing Provider NPI/Tax ID: _____ Servicing Provider's Fax #: _____

CLINICAL INFORMATION	
□ Initial Request □ Continuation of Therapy Request	Date(s) of Service Requested:
Requested J-Code(s) for the entire treatment regimen:	Requested CPT code(s):
Directions:	# of Units Requested:
Diagnosis/ICD-10 code(s):	

Please check all that apply and submit appropriate documentation (if applicable):

□ **Member has diagnosis of Acute Lymphoblastic Leukemia (ALL):**
- □ Member has confirmed documentation of CD19 tumor expression (demonstrated in bone marrow or peripheral blood by flow cytometry) **AND**
- □ Member has not previously experienced treatment failure on Kymriah® or Yescarta® **AND**
- □ Member has experienced disease relapse after allogeneic stem cell transplantation (SCT) and member is ≥ 6 months from above transplantation at the time of infusion **OR**
- □ Member has relapsed/refractory Philadelphia chromosome-negative B-ALL that has progressed after 2 cycles of a standard chemotherapy regimen for initial diagnosis OR after 1 cycle of standard chemotherapy for relapsed leukemia **OR**
- □ Member has relapsed/refractory Philadelphia chromosome-positive B-ALL that has progressed after failure of 2 TKI-containing regimens

□ **Member has diagnosis of B-Cell Lymphomas:**
- □ The member has grade 1-2 relapsed or refractory follicular lymphoma or relapsed/refractory DLBCL- Diffuse Large B-Cell Lymphoma **AND** member has experienced disease progression after two or more lines of systemic therapy (if Kymriah® or Yescarta® not previously given)

Please provide any additional clinical information and/or submit any other pertinent clinical documentation for review

THIS FORM MUST BE SIGNED BY A PHYSICIAN	
Signature of Requesting Provider:	Date:

This authorization is not a guarantee of reimbursement. Claim payments are subject to the following, which include but are not limited to, Neighborhood Health Plan of Rhode Island benefit coverage, member eligibility, claims payment edit rules, coding and documentation guidelines, authorization policies, provider contract agreements, and state and federal regulations.