peach state health plan

Afamitresgene Autoleucel (Tecelra)
Prior Authorization Form/Prescription

Telephone: (800) 514-0083 option 2
Fax: (866) 374-1579

Date: _____ Date Medication Required: _____
Ship to: ❍ Physician ❍ Patient's Home ❍ Other _____

Patient Information

*Last Name:	*First Name:	Middle:	*DOB: ____ /____ /_____
Daytime Phone:	Evening Phone:	*Sex: ☐ Male ☐ Female	

Insurance Information (*Attach copies of cards*)

*Primary Insurance:		Secondary Insurance:	
*ID #:	Group #:	ID #:	Group #:

Physician Information

*Name:	*Specialty:	NPI:
*Phone #:	Secure Fax #:	Office Contact:

Procedural Hospital

*Hospital Name:

Primary Diagnosis

*ICD-10 Code: _____

☐Advanced synovial sarcoma ☐ Myxoid/round cell liposarcoma (MRCLS) ☐Other: _____

Prescription Information

MEDICATION	STRENGTH	*DIRECTIONS	QUANTITY	REFILLS
Tecelra (Afamitresgene Autoleucel)				

Clinical Information ***** *Please submit supporting clinical documentation* *****

* **THERAPY TYPE (choose one):** ☐INITIAL THERAPY ☐CONTINUATION OF THERAPY
Therapy start date: _____

If prescribed dose exceeds the FDA maximum recommended dose, please submit supporting practice guidelines/peer-reviewed literature

1. Is therapy prescribed by or in consultation with a medical oncologist? ☐Yes ☐No
2. Is request for initial treatment dose only? ☐Yes ☐No
3. Is disease positive by one of the following? ☐Yes ***Mark all that apply*** ☐No
   ☐HLA-A*02:01
   ☐HLA-A*02:02
   ☐HLA-A*02:03
   ☐HLA-A*02:06
   ☐Other: _____
4. Has member previously received either an anthracycline or ifosfamide-containing regimen? ☐Yes ***Mark all that apply*** ☐No
   ☐AIM (doxorubicin, ifosfamide mesna) ☐AD (doxorubicin, dacarbazine) ☐Ifosfamide, eriprubicin, mesna
   ☐Doxorubicin ☐Epirubicin ☐Liposomal doxorubicin
5. Does documentation exist for MAGE-A4 expression of 1 or greater staining in at least 10% of the cells as determined by immunohistochemistry? ☐Yes ***Please submit documentation*** ☐No
6. Has member received prior gene therapy using a retroviral vector? ☐Yes ***Mark all that apply*** ☐No
   ☐Yescarta ☐Tecartus

Complete this section ONLY for indications <u>other</u> than Advanced synovial sarcoma or MRCLS:

7. Has patient tried and failed, or is contraindicated to, accepted standards of care? ☐Yes ☐No
   If yes, submit documentation and answer the following:
   a. Please list all previous therapies: _____
   b. Was patient adherent to previously tried therapies? ☐Yes ☐No ☐No, patient intolerant to drug

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Please continue to page 2.

Patient Name: _____ **DOB:** _____

Physician's Signature: _____ **Date:** _____ ☐DAW

INFORMATION BELOW IS TO BE COMPLETE BY THE HEALTH PLAN/ CPS PA STAFF

Authorization Information

***Authorization number:**	***Decision Due Date:**
***J-Code:**	***Coverage:** ☐ State excludes ☐ COB (secondary)
***Line of Business:** ☐ Commercial ☐ Health Insurance Marketplace ☐ Medicaid ☐ Medicare	***Benefit:** ☐ Medical ☐ Pharmacy

***Choose one criteria option below based on line of business:**

Medicare Criteria Only:

☐ Medicare Local Coverage Decision (LCD) specific for your region
Please include policy of link to LCD, followed by any applicable Medicare Part B step therapy requirements in MCPB.ST.00. _____

☐ Medicare National Coverage Decision (NCD).
Please include policy of link to NCD, followed by any applicable Medicare Part B step therapy requirements in MCPB.ST.00. _____

Medicaid, Commercial, Exchange (Ambetter) Criteria:

☐ Centene Policy [**CP.PHAR.602 Atidarsagene Autotemcel (Lenmeldy)**]
Date Policy last reviewed/approved by plan (we want to be sure we are using the version approved by your plan):
_____

OR

☐ State or Health Plan Specific (please include policy) _____