Lifileucel (Amtagvi)
Prior Authorization Form/Prescription

peach state health plan

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: _____
☐Melanoma ☐Other: _____

Prescription Information

MEDICATION	STRENGTH	*DIRECTIONS	QUANTITY	REFILLS
Amtagvi (Lifileucel)				

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

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

1. Is therapy prescribed by or in consultation with an oncologist? ☐Yes ☐No
2. Is patient's melanoma unresectable or metastatic? ☐Yes ☐No
3. Is patient's melanoma BRAF V600 mutation positive? ☐Yes ☐No
4. Is there documentation of disease progression, inadequate response, or intolerance while on the following regimens?
   ☐Yes **Mark all that apply** ☐No

   Anti-PD-1/PD-L1 targeted therapy
   ☐Keytruda ☐Opdualag ☐Tecentriq
   ☐Opdivo ☐Opdivo with Yervoy

   BRAF/BRAF-MEK targeted therapy
   ☐Tafinlar ☐Braftovi ☐Zelboraf
   ☐Mektovi ☐Mekinist ☐Cotellic
5. Is Amtagvi prescribed in combination with IL-2* therapy (e.g., aldesleukin)? ☐Yes ☐No
6. Is there documentation the patient has at least one resectable lesion (or aggregate of lesions resected) with a minimum diameter of 1.5 cm in diameter? ☐Yes ☐No
7. Is there documentation the patient's melanoma is not of known uveal/ocular origin? ☐Yes ☐No
8. Has patient received an organ allograft or treatment with prior TIL therapy or prior chimeric antigen receptor T-cell (CAR-T) therapy (e.g., Breyanzi, Kymriah, Tecartus, Yescarta, Carvykti)? ☐Yes ☐No

Complete this section ONLY for indications <u>other</u> than melanoma:

9. 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

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

Please continue to page 2.

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Patient Name: _____ **DOB:** _____

INFORMATION BELOW IS TO BE COMPLETED 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.598 Lifileucel (Amtagvi)**]
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) _____