Anti-Neoplastic: B-Cell Lymphoma Drugs

Besponsa (inotuzumab ozogam) J9229, Blincyto (blinatumomab) J9039, Campath/Lemtrada (alemtuzumab) J0202, Polivy (polatuzumab) J9309, Zynlonta (loncastuximab tesirine-lpyl) J9359, Yescarta (Axicabtagene ciloleucel) Q2041

Prior Authorization Request

Medicare Part B Form

*Instructions: * Indicates required information – Form may be returned if required information is not provided. Please fax this request to the appropriate fax number listed at the bottom of the page.*

☐	**Standard Request– (72 Hours)**	☐	**Urgent Request** (standard time frame could place the member's life, health or ability in serious jeopardy)
	Date Requested _____		
	Requestor _____ Clinic name: _____ Phone / Fax		

MEMBER INFORMATION

*Name:_____ *ID#:_____ *DOB:_____

PRESCRIBER INFORMATION

*Name:_____ ☐MD ☐FNP ☐DO ☐NP ☐PA *Phone:_____

*Address:_____ *Fax:_____

DISPENSING PROVIDER / ADMINISTRATION INFORMATION

*Name:_____ Phone:_____

*Address:_____ Fax:_____

PROCEDURE / PRODUCT INFORMATION

HCPC Code	Name of Drug	Dose (Wt: _____ kg Ht:_____)	Frequency	End Date if known

☐ **Self-administered** ☐ **Provider-administered** ☐ **Home Infusion**

☐Chart notes attached. **Other important information:**_____

Diagnosis: ICD10: _____ **Description**: _____

☐ Provider attests the diagnosis provided is an FDA-Approved indication for this drug

CLINICAL INFORMATION

☐ New Start or Initial Request: (Clinical documentation required for all requests)

☐ **Provider has reviewed the attached "Criteria for Approval" and attests the member meets ALL required PA criteria.**

If not, please provide **clinical rationale** for formulary exception: _____

_____

☐ Continuation Requests: (Clinical documentation required for all requests)

☐ **Provider has reviewed the attached "Criteria for Continuation" and attests the member meets ALL required PA Continuation criteria.**

☐ Patient had an adequate response or significant improvement while on this medication.

If not, please provide clinical rationale for continuing this medication: _____

_____

ACKNOWLEDGEMENT

Request By (Signature Required): _____Date:_____ /____ /____

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. **THIS AUTHORIZATION IS NOT A GUARANTEE OF PAYMENT.** PAYMENT IS BASED ON BENEFITS IN EFFECT AT THE TIME OF SERVICE, MEMBER ELIGIBILITY AND MEDICAL NECESSITY.

Prior Authorization Group – Oncology: B-Cell Lymphoma Drugs PA

Drug Name(s):

BESPONSA	**BLINCYTO**
CAMPATH	**LEMTRADA**
POLIVY	**ZYNLONTA**
YESCARTA	**AXICABTAGENE CILOLEUCEL**

Criteria for approval of Prior Authorization Drug:

1. Prescribed for an approved FDA diagnosis (as listed below):
2. Prescribed by, or in consultation with an oncologist or other cancer specialist related to the diagnosis.
3. Drug is being used appropriately per CMS recognized compendia, authoritative medical literature, evidence-based guidelines and/or accepted standards of medical practice.
4. Member does not have any clinically relevant contraindications, or CMS/Plan exclusions, to the requested drug.

- If the member meets all these criteria, they may be approved by the Plan for the requested drug.
- Quantity limits and Tiering will be determined by the Plan.

Exclusion Criteria:

Cannot be prescribed for experimental or investigational use.

Prescriber Restrictions:

Oncologist or other cancer specialist
Lemtrada: Neurologist, Oncologist or other relevant specialist

Coverage Duration:

New Start: Approval will be for 6 months
Continuation: Approval will be for 12 months

FDA Indications:

Besponsa

- Precursor B-cell acute lymphoblastic leukemia, relapsed or refractory

Blincyto

- B-cell acute lymphoblastic leukemia, CD19-positive disease in first or second complete remission with minimal residual disease-positive (0.1% or greater)
- B-cell acute lymphoblastic leukemia, relapsed or refractory, CD19-positive disease

Campath

- B-cell chronic lymphocytic leukemia, Monotherapy

Lemtrada

- Relapsing remitting multiple sclerosis (inadequate response to two or more drugs indicated for treatment of MS)

Polivy

- Diffuse large B-cell lymphoma, relapsed or refractory, in combination with bendamustine and a rituximab product, after at least 2 prior therapies

Off-Label Uses:

Campath/Lemtrada

- Autoimmune disease - Cytopenia
- Cardiac transplant rejection; prophylaxis
- Chronic lymphoid leukemia
- Graft versus host disease, In patients receiving allogeneic stem cell transplant for hematologic malignancies, steroid-refractory
- Malignant tumor of lymphoid hemopoietic and related tissue
- Primary cutaneous T-cell lymphoma, Relapsed or refractory
- Rejection of intestine transplant; prophylaxis
- Rejection of pancreas transplant; prophylaxis
- Renal transplant rejection, Induction therapy; Prophylaxis
- T-cell prolymphocytic leukemia

Polivy

- Diffuse large B-cell lymphoma, Intermediate- or high-risk, previously untreated, in combination with cyclophosphamide, DOXOrubicin, predniSONE, and rituximab

Yescarta

- B-cell lymphoma, Large, relapsed or refractory, after 2 or more lines of systemic therapy
- B-cell lymphoma, Large, relapse within 12 months or refractory to first-line chemoimmunotherapy
- Follicular lymphoma, Relapsed or refractory after 2 or more lines of systemic therapy

Zynlonta

- B-cell lymphoma, Large, relapsed or refractory, after 2 or more lines of systemic therapy

Age Restrictions:

Besponsa, Pollivy: Safety and effectiveness not established in pediatric patients

Other Clinical Considerations:

Cancer diagnoses: Criteria as per NCCN or other FDA-approved cancer related guidelines.

Resources:

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