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## YESCARTA PRIOR AUTHORIZATION REQUEST FORM

This form **MUST BE** submitted with medical records to support services

Date:		
<b>RECEIPIENT INFORMATION</b>		
Medicaid ID:	Date of Birth:	Sex:    M        F
Last Name:		First Name:
<b>GENERAL INFORMATION</b>		
First Date of Service:		Last Date of Service:
Primary Diagnosis Code:		HCPC Code:
Drug Name:		Dose & Frequency:
Hospitalizations/Treatments/Medications Used in the last 6 months:		
<b>POINT OF CONTACT</b>		
Name and Title:		
Email:	Phone:	Fax:
<small><i>Note: The point of contact is the individual completing the PA and would be the contact for questions SD Medicaid may have regarding the PA. The determination notice will be sent to the listed point of contact.</i></small>		
<b>REFERRING PROVIDER INFORMATION</b>		
Name:		
NPI #:		Taxonomy:
Phone:		Fax:
<b>SERVICING PROVIDER INFORMATION</b>		
Name:		
Address:		
NPI #:		Taxonomy:
Phone:		Fax:

CRITERIA		
Medical records to support use of product are submitted		
Initial Therapy (check one)	Yes	No
	Therapy is prescribed by a hematologist or oncologist	
	Individual has a diagnosis of <b>one</b> of the following: <ul style="list-style-type: none"> <li>• Follicular lymphoma</li> <li>• Large B-cell lymphoma</li> </ul>	
	Individual meets <b>one</b> of the following regarding previous therapy failures: <ul style="list-style-type: none"> <li>• Follicular lymphoma: documentation is provided indicating failure after <math>\geq 2</math> lines of systemic therapy</li> <li>• Large B-cell lymphoma (<b>must meet one</b>): <ul style="list-style-type: none"> <li>○ Documentation is submitted indicating that disease is refractory to first line chemotherapy</li> <li>○ Documentation is submitted indicating disease relapsed within 12 months of first line chemotherapy</li> <li>○ Documentation is provided indicating failure after <math>\geq 2</math> lines of systemic therapy (including diffuse large B-cell lymphoma (DLBCL) not otherwise specified, primary mediastinal large B-cell lymphoma, high grade B-cell lymphoma and DLBCL arising from follicular lymphoma)</li> </ul> </li> </ul>	
	Individual does not have diagnosis of primary CNS lymphoma	
	Member has not received Car-T therapy in the past and therapy will not be utilized in conjunction with other Car-T therapies	
	Individual is $\geq 18$ years of age	
PHYSICIAN SIGNATURE – PROVIDER ONLY		
This form <u>must be</u> signed by a provider		
	I certify that the information given in this form is a true and accurate medical indication for the required product	
<b>Name &amp; Title (Printed):</b>		<b>Specialty:</b>
<b>Signature:</b>		