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## TECARTUS 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>• B-cell precursor, acute lymphoblastic leukemia</li> <li>• Mantle cell lymphoma</li> </ul>   |     |            |
| Disease is relapsed or refractory and meets <b>one</b> of the following as specified per indication <ul style="list-style-type: none"> <li>• Acute lymphoblastic leukemia (must meet <b>one</b>): <ul style="list-style-type: none"> <li>○ Disease is classified as primary refractory</li> <li>○ Disease is in first relapse if first remission is <math>\leq 12</math> months</li> <li>○ Disease is relapsed or refractory after <math>\geq 2</math> lines of systemic therapy</li> <li>○ Disease is relapsed following allogenic stem cell transplantation (allo-SCT) and must be <math>\geq 100</math> days from allo-SCT at the time of Tecartus infusion</li> </ul> </li> <li>• Mantle cell lymphoma: documentation is submitted indicating failure with <b>all</b> the following (which may or may not include therapy supported by autologous stem cell transplant): <ul style="list-style-type: none"> <li>○ Anthracycline- or bendamustine- containing chemotherapy</li> <li>○ Anti-CD20 monoclonal antibody</li> <li>○ Bruton's tyrosine kinase (BTK) inhibitor</li> </ul> </li> </ul> |     |            |
| Individual is $\geq 18$ years of age  |     |            |
| Member has not received Car-T therapy in the past and therapy will not be utilized in conjunction with other Car-T therapies  |     |            |
| 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  |     |            |
| Name & Title (Printed):   |     | Specialty: |
| Signature:  |     |            |