



PHONE: 605-773-3495 | FAX: 605-773-5246

WEB: [DSS Medicaid Prior Authorizations](#) | EMAIL : [DSSMedicaidpa@state.sd.us](mailto:DSSMedicaidpa@state.sd.us)

## BREYANZI 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:

<b>CRITERIA</b>		
<b>Medical records to support use of product are submitted</b>		
<b>Initial Therapy (check one)</b>	<b>Yes</b>	<b>No</b>
	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>• Chronic lymphocytic leukemia or small lymphocytic lymphoma</li> <li>• Follicular lymphoma</li> <li>• Large B-cell lymphoma</li> <li>• Mantle cell lymphoma</li> </ul>	
	Disease is classified as relapsed or refractory and individual meets <b>one</b> of the following regarding previous therapy failures: <ul style="list-style-type: none"> <li>• Chronic lymphocytic leukemia or small lymphocytic lymphoma: documentation is submitted indicating failure after <math>\geq 2</math> prior lines of therapy including a Bruton tyrosine kinase (BTK) inhibitor and a B-cell lymphoma 2 (BCL-2) inhibitor</li> <li>• Follicular lymphoma: documentation is submitted indicating failure after <math>\geq 2</math> prior lines of therapy</li> <li>• Large B-cell lymphoma (including diffuse large B-cell lymphoma (DLBCL) not otherwise specified (including DLBCL arising from indolent lymphoma), high-grade B-cell lymphoma, primary mediastinal large B-cell lymphoma, and follicular lymphoma grade 3B) (must meet <b>one</b>):               <ul style="list-style-type: none"> <li>• Disease is refractory to first line chemotherapy</li> <li>• Relapse within the first 12 months of first line chemotherapy</li> <li>• Disease is refractory to first line chemotherapy or relapse after first line chemotherapy and individual is not eligible for hematopoietic cell transplantation due to comorbidities/age</li> <li>• Documentation is submitted indicating failure after <math>\geq 2</math> lines of systemic therapy</li> </ul> </li> <li>• Mantle cell lymphoma: documentation is submitted indicating failure after <math>\geq 2</math> prior lines of therapy including a Bruton tyrosine kinase (BTK) inhibitor</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	
<b>PHYSICIAN SIGNATURE – PROVIDER ONLY</b>		
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>		