HUSKY Health Program KYMRIAH™
Prior Authorization Request Form
Phone: 1.800.440.5071

THIS FORM IS TO BE COMPLETED BY THE ORDERING PROVIDER AND FAXED WITH CLINICAL DOCUMENTATION TO 203.265.3994

Member Information					
Member ID #:				Member Name (Last, First):	
Address:				City, State, Zip:	
DOB:	Age:	Sex:	Weight in kg:	Primary ICD-10 DX Code:	Kymriah™ Dose:

Please fill out completely.		
1. Does the patient have a diagnosis of B-cell precursor acute lymphoblastic leukemia?	□ Yes	□ No
2. Is the disease refractory or in second or later relapse? *Please check all that apply* □ Second or greater bone marrow relapse □ Bone marrow relapse after allogenic stem cell transplant □ Primary refractory after 2 cycles of standard chemotherapy □ Not eligible for allogenic stem cell transplant □ Chemorefractory after 1 cycle of standard chemotherapy for relapsed disease □ Ph + with failed TKI treatment (2 prior lines)	□ Yes	□ No
3. Does the patient have confirmed CD 19 tumor expression?	□ Yes	□ No
4. Has the patient previously been treated with gene therapy or Kymriah™?	□ Yes	□ No
5. Does the patient have any of the following? *Please check all that apply* □ Serious unresolved adverse reactions from previous chemotherapy □ Active graft versus host disease □ Worsening leukemia burden, including active CNS malignancy involvement □ Active infection □ Inflammatory disorder	□ Yes	□ No
6. Has Hepatitis B infection been ruled out or has treatment been given?	□ Yes	□ No
7. Has the patient been screened for Hepatitis C and HIV infection?	□ Yes	□ No
8. Has the individual received live vaccines within the past two weeks?	□ Yes	□ No
9. Has prophylaxis for infection been given?	□ Yes	□ No
10. Will the patient receive lymphodepleting therapy within the two weeks prior to Kymriah™ therapy?	□ Yes	□ No
11. Will the patient be monitored for cytokine release syndrome and neurological toxicities?	□ Yes	□ No
12. Is tocilizumab available for administration if needed?	□ Yes	□ No
13. Is the facility where Kymriah™ therapy will be administered certified by the Risk Evaluation and Mitigation Strategies (REMS) program? *Please attach documentation*	□ Yes	□ No

Note: Review criteria are used as guidelines only. Determinations are based on a person-centered assessment of the individual and their unique clinical needs. Additional information submitted with this request will be considered as part of the medical necessity review process, in accordance with Conn. Gen. Stat. Sec. 17b-259b.

Billing Provider Information		
Medicaid Billing Number:		Billing Provider Name:
Street Address:		City, State, Zip:
Phone #:	Fax #:	Contact Name:

Ordering Provider Information		
Medicaid Billing Number:		Ordering Provider Name:
Street Address:		City, State, Zip:
Phone #:	Fax #:	Contact Name:

Certification Statement: This is to certify that the requested medication is medically indicated and is reasonable and necessary for the treatment of this patient and that a prescribing practitioner signed order is on file. This form and any statement on my letterhead attached hereto has been completed by me or by my employee and reviewed by me. The foregoing information is true, accurate and complete, and I understand that any falsification, omission, or concealment of material fact may subject me to civil and criminal liability.

Physician Signature:	**Date:**