KAISER PERMANENTE®

10/3/2022

PHARMACY REVIEW SERVICES
PHONE: (206) 901-4700
FAX: (800) 377-8853

PATIENT:			
DOB:		**MEMBER #:**	
PRESCRIBER:		**ALT #:**	
ADMIN LOCATION:		**DX CODE (S):**	

Kymriah (tisagenlecleucel)
Office Administered Prior Authorization Drug Request Form
Please provide any or all clinical chart notes along with this page

Diagnosis: Diffuse Large B-Cell Lymphoma
☐ YES ☐ NO (If YES, check all criteria that apply below)
☐ Patient has primary refractory or relapse disease within one year

Diagnosis: Philadelphia Chromosome Negative Acute Lymphoblastic Leukemia Ph(-) ALL:
☐ YES ☐ NO (If YES, check all criteria that apply below)
☐ YES ☐ NO Patient is 18- 25 years old and has less than complete response after extended remission induction
☐ YES ☐ NO Patient is 40 years and older is not a candidate for intensive chemotherapy

Diagnosis: Philadelphia Chromosome Positive Acute Lymphoblastic Leukemia Ph(+) ALL:
☐ YES ☐ NO (If YES, check all criteria that apply below)
☐ YES ☐ NO Patient is not a candidate for intensive chemotherapy and who have received dasatinib with prednisone or blinatumomab and has less than complete response
☐ YES ☐ NO Patient has received intensive chemotherapy with TKI therapy
AND
☐ YES ☐ NO Patient is not MRD negative at 3 months
AND
☐ YES ☐ NO Patient is bridging to transplant

Does patient have any of the following exclusion criteria listed below:
☐ YES ☐ NO Has patient received prior CAR-T therapy or other genetically modified T cell therapy

Authorization duration: limited to a one-time (single infusion) treatment