



03/29/2024

PHARMACY REVIEW SERVICES

PHONE: (206) 901-4700

FAX: (800) 377-8853

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

Tecartus (brexucabtagene autoleucel)

Office Administered Prior Authorization Drug Request Form

Please provide any or all clinical chart notes along with this page

Diagnosis: Philadelphia Chromosome Negative Acute Lymphoblastic Leukemia Ph(-):

☐ YES ☐ NO (If YES, check all criteria that apply below)

☐ YES ☐ NO Patient is 25 years old and younger and has less than CR after extended remission induction

☐ YES ☐ NO Patient is 40 years and older who is not a candidate for intensive chemotherapy

Diagnosis: Philadelphia Chromosome Positive Acute Lymphoblastic Leukemia Ph(+):

☐ YES ☐ NO (If YES, check all criteria that apply below)

☐ YES ☐ NO Patient has received intensive chemotherapy with TKI therapy
AND

☐ YES ☐ NO Patient is not MRD negative at 3 months

Diagnosis: Relapsed or Refractory Mantle Cell Lymphoma

☐ YES ☐ NO (If YES, check all criteria that apply below)

☐ YES ☐ NO Patient has Stage I, II disease post prior chemotherapy +RT followed by BTK inhibitor or additional novel chemotherapy resulting in partial response or refractory disease

☐ YES ☐ NO Patient has relapse after Stem cell transplant

☐ YES ☐ NO Patient has stage II (bulky), III, IV for patients with partial response to initial treatment of refractory disease

Does patient have any of the following exclusion criteria listed below:

☐ YES ☐ NO Burkitt's lymphoma/leukemia?

☐ YES ☐ NO Active hepatitis B, C, or any uncontrolled infection?

☐ YES ☐ NO Active Grade 2 to 4 Graft versus Host Disease (GVHD)?

☐ YES ☐ NO Central Nervous System (CNS) disease (white blood cell count $\geq 5/\text{mL}$ with blasts on cytocentrifuge and/or signs of CNS leukemia (e.g., cranial nerve palsy)?

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