



MASSACHUSETTS

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CAR T-Cell Therapy Services for the Treatment of Diffuse Large B-cell Lymphoma (axicabtagene cilleucel or tisagenlecleucel) Prior Authorization Request Form #924

Medical Policy #455 Adoptive Immunotherapy including CAR T-Cell Therapy

Please use this form to assist in identifying members who meet Blue Cross Blue Shield of Massachusetts' (BCBSMA's) medical necessity criteria for CAR T-Cell Therapy Services for the Treatment of Diffuse Large B-cell Lymphoma (axicabtagene cilleucel or tisagenlecleucel). For members who do not meet the criteria, submit a letter of medical necessity with a request for [Clinical Exception \(Individual Consideration\)](#). Once completed, fax to:

Medical and Surgical: 1-888-282-0780	Medicare Advantage: 1-800-447-2994
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CLINICAL DOCUMENTATION
Copies of clinical documentation that supports the medical necessity criteria for [CAR T-Cell Therapy Services for the Treatment of Diffuse Large B-cell Lymphoma \(axicabtagene cilleucel or tisagenlecleucel\)](#) must be submitted with this form. **If the patient does not meet all the criteria listed below, please submit a letter of medical necessity explaining why an exception is justified.**

Patient Information	
Patient Name:	Today's Date:
BCBSMA ID#:	Date of Treatment:
Date of Birth:	Place of Service: Outpatient <input type="checkbox"/> Inpatient <input type="checkbox"/>

Physician Information	Facility Information
Name:	Name:
Address:	Address:
Phone #:	Phone #:
Fax#:	Fax#:
NPI#:	NPI#:

Please check off if the patient has ONE of the following histologically confirmed diagnoses and HAS RELAPSED or is REFRACTORY ^a :	
Diffuse large B-cell lymphoma, not otherwise specified	<input type="checkbox"/>
Primary mediastinal large B-cell lymphoma	<input type="checkbox"/>
High-grade B-cell lymphoma ^b	<input type="checkbox"/>
Diffuse large B-cell lymphoma arising from follicular lymphoma	<input type="checkbox"/>

^a Relapsed or refractory disease, defined as progression after 2 or more lines of systemic therapy (which may or may not include therapy supported by autologous cell transplant).

^b Tisagenlecleucel intravenous infusion is considered investigational for the treatment of relapsed or refractory primary mediastinal large B-cell lymphoma.

Please check off that the patient meets ALL the following criteria:	
Adult (age ≥18) at the time of infusion	<input type="checkbox"/>
Received adequate prior therapy including all of the following: <ul style="list-style-type: none"> • Anti-CD20 monoclonal antibody for CD20-positive tumor • Anthracycline-containing chemotherapy regimen • For subjects with transformed follicular lymphoma, prior chemotherapy for follicular lymphoma and subsequently have chemorefractory disease after transformation to diffuse large B-cell lymphoma 	<input type="checkbox"/>
If patient has a history of allogeneic stem cell transplant, has no signs of active graft versus host disease	<input type="checkbox"/>
No active autoimmune disease requiring systemic immunosuppression	<input type="checkbox"/>
Has adequate organ and bone marrow function as determined by the treating oncologist/hematologist with no significant deterioration in organ function expected within 4 weeks after apheresis	<input type="checkbox"/>
Has not received prior CD19-directed CAR T-cell therapy treatment or any other gene therapy or are being considered for treatment with any other gene therapy, AND	<input type="checkbox"/>
Does not have primary central nervous system lymphoma.	<input type="checkbox"/>

Please check off if the facility is part of Risk Evaluation and Mitigation Strategy (REMS)	
The facility delivering the therapy is certified by Kite Pharma that it has an adequate REMS protocol (Risk Evaluation and Mitigation Strategy) to address a cytokine release syndrome and neurotoxicity	<input type="checkbox"/>

Note: Other adoptive immunotherapy, using adoptive cellular therapy for the administration of cytotoxic T-lymphocytes, cytokine-induced killer cells, tumor-infiltrating lymphocytes, antigen-loaded autologous dendritic cells, or genetically-engineered T-cells is considered **INVESTIGATIONAL**.

CPT CODES/ HCPCS CODES/ ICD CODES

HCPCS codes:	Code Description	
C9399	Unclassified drugs or biologicals	<input type="checkbox"/>
J3490	Unclassified drugs	<input type="checkbox"/>
J3590	Unclassified biologics	<input type="checkbox"/>
J9999	Not otherwise classified, antineoplastic drugs	<input type="checkbox"/>
Q2041	Axicabtagene Ciloleucel, up to 200 Million Autologous Anti-CD19 CAR T Cells, Including Leukapheresis And Dose Preparation Procedures, Per Infusion	<input type="checkbox"/>
Q2042	Tisagenlecleucel, up to 600 million car-positive viable t cells, including leukapheresis and dose preparation procedures, per therapeutic dose	<input type="checkbox"/>
S2107	Adoptive immunotherapy, i.e., development of specific anti-tumor reactivity (e.g., tumor infiltrating lymphocyte therapy) per course of treatment	<input type="checkbox"/>

Providers should enter the **relevant diagnosis code(s)** below:

Code	Description	
		<input type="checkbox"/>
		<input type="checkbox"/>

Providers should enter **other relevant code(s)** below:

Code	Description	
		<input type="checkbox"/>

		<input type="checkbox"/>
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