Yescarta® (intravenous axicabtagene)
Prior Authorization Form
Fax: 1-844-639-7906
Pharmacy Dept. Phone: 1-401-427-8200

Please complete the form by providing all of the following information. Failure to fill out this form in its entirety may delay the review process. To review the Clinical Medical Policies, please visit our website at https://www.nhpri.org/Providers/ClinicalMedicalPolicies.aspx

MEMBER INFORMATION		
Member's Name:	Member's ID Number:	Member's DOB:
REQUESTING PROVIDER INFORMATION		
Provider's Name:	Provider's Phone #:	Provider's Fax #:
Provider's NPI #:	Provider's Contact Name and Phone #:	

SERVICING PROVIDER INFORMATION (Must be filled out appropriately to ensure claim adjudication)

HOW WILL MEDICATION BE OBTAINED:

□ Drop Ship from Specialty Pharmacy: _____ NPI: _____

□ If Buy and bill, please provide the following information for the servicing provider: □ Same as Requesting Provider
Servicing Provider/Facility Name: _____
Servicing Provider NPI/Tax ID: _____ Servicing Provider's Fax #: _____

CLINICAL INFORMATION	
□ Initial Request □ Continuation of Therapy Request	Date(s) of Service Requested:
Requested J-Code(s) for the entire treatment regimen:	Requested CPT code(s):
Directions:	# of Units Requested:
Diagnosis/ICD-10 code(s):	

Please check all that apply and submit appropriate documentation (if applicable):

□ **Member has diagnosis of Non-Hodgkin Lymphomas (NHL):**
- □ Please specify the type of aggressive NHL:
  - □ Diffuse Large B Cell Lymphoma (DLBCL)
  - □ Primary Mediastinal Large B Cell Lymphoma (PMBCL)
  - □ Transformed Follicular Lymphoma (TFL) (transformed to Diffuse Large B-Cell or other high grade lymphoma)
  - □ High-grade B-cell lymphomas with translocations of MYC and BCL2 and/or BCL6 (double/triple hit lymphoma) or high-grade B-cell lymphomas, not otherwise specified
  - □ Monomorphic post-transplant lymphoproliferative disorders (B-cell type) **AND**
- □ Member has chemotherapy-refractory disease, defined as one or more of the following:
  - □ No response to last line of therapy **OR**
  - □ Disease progression or relapse ≤12 months after autologous stem-cell transplantation (ASCT) **AND**
- □ Member had prior therapy with anti-CD20 monoclonal antibody (i.e. rituximab or obinutuzumab) **AND** an anthracycline (i.e. CHOP) containing chemotherapy regimen

Please provide any additional clinical information and/or submit any other pertinent clinical documentation for review

THIS FORM MUST BE SIGNED BY A PHYSICIAN

Signature of Requesting Provider:	Date:

This authorization is not a guarantee of reimbursement. Claim payments are subject to the following, which include but are not limited to, Neighborhood Health Plan of Rhode Island benefit coverage, member eligibility, claims payment edit rules, coding and documentation guidelines, authorization policies, provider contract agreements, and state and federal regulations.