OKLAHOMA Health Care Authority

SoonerSelect | aetna

State of Oklahoma SoonerCare
Tecartus® (Brexucabtagene Autoleucel) Prior Authorization Form

Member Name: _____ ***Date of Birth:*** _____ ***Member ID#:*** _____

Drug Information

☐ **Physician billing (HCPCS code:** _____**)** ***Start Date:*** _____

Billing Provider Information

SoonerCare Provider ID: _____ ***Provider Name:*** _____

Provider Phone: _____ ***Provider Fax:*** _____

Prescriber Information

Prescriber NPI: _____ ***Prescriber Name:*** _____

Prescriber Phone: _____ ***Prescriber Fax:*** _____ ***Specialty:*** _____

Criteria

For Authorization:

1. Please include the most recent office visit note or clinical summary from the hospital to support your request. Is this information attached? Yes☐ No☐
2. Is the health care facility on the certified list to administer CAR T-cells? Yes☐ No☐
3. Is the health care facility trained in the management of cytokine release syndrome (CRS) and neurologic toxicities? Yes☐ No☐
4. Will the health care facility comply with the Tecartus® Risk Evaluation and Mitigation Strategy (REMS) Program requirements? Yes☐ No☐
5. Please indicate the diagnosis and information:
   - ☐ **Mantle cell lymphoma**
     - A. Does member have relapsed or refractory disease? Yes☐ No☐
   - ☐ **Acute Lymphoblastic Leukemia**
     - A. Does member have relapsed or refractory disease? Yes☐ No☐
   - ☐ **If answer is none of the above, please indicate diagnosis:** _____

Additional Information: _____

_____

_____

Prescriber Signature: _____ **Date:** _____

I certify that the indicated treatment is medically necessary and all information is true and correct to the best of my knowledge.

Failure to complete this form in full and attach requested clinical notes will result in processing delays.

Fax completed prior authorization request form to **888-601-8461** or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts. All requested data must be provided. Incomplete forms or forms without the chart notes will be returned. Pharmacy Coverage Guidelines are available at **AetnaBetterHealth.com/Oklahoma.**	CONFIDENTIALITY NOTICE *This document, including any attachments, contains information which is confidential or privileged. If you are not the intended recipient, be aware that any disclosure, copying, distribution, or use of the contents of this information is prohibited. If you have received this document in error, please notify the sender immediately by telephone to arrange for the return of the transmitted documents or to verify their destruction.*