



**Executive Office of Health & Human  
Services**

**MEDICAID FEE FOR SERVICE (FFS) PRIOR AUTHORIZATION REQUEST FORM**  
DXC Technology ATTN: PHARMACIST  
FAX (401) 784-3889 • PH (401) 784-8100

PATIENT NAME: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ ID NUMBER: \_\_\_\_\_

PRESCRIBER NAME: \_\_\_\_\_ PRESCRIBER NPI #: \_\_\_\_\_

OFFICE PHONE NUMBER: ( ) \_\_\_\_\_ OFFICE FAX NUMBER: ( ) \_\_\_\_\_

RENDERING PROVIDER NAME: \_\_\_\_\_ RENDERING PROVIDER NPI #: \_\_\_\_\_

**SUPPORTING DOCUMENTATION SHOULD BE MAINTAINED WITH THE PATIENT RECORD. ADDITIONAL DOCUMENTATION SHOULD BE SUBMITTED ONLY IF REQUESTED BY RI EOHHS.**

**CLINICAL INFORMATION:**

a. CAR T REQUESTED (SELECT ONE): \_\_\_\_\_ KYMRIA<sup>®</sup> (tisagenlecleucel) Q2040 or \_\_\_\_\_ YESCARTA<sup>™</sup> (axicabtagene ciloleucel) Q2041

b. REQUESTED DATE OF TREATMENT: \_\_\_\_\_

c. DIAGNOSIS: \_\_\_\_\_ ICD 10 CODE: \_\_\_\_\_

d. CURRENT CLINICAL STATUS:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

e. HAS THE PATIENT HAD PRIOR THERAPY WITH GENE THERAPY: \_\_\_\_\_ YES \_\_\_\_\_ NO

f. HAS THE PATIENT FAILED AT LEAST TWO LINES OF THERAPY? \_\_\_\_\_ YES \_\_\_\_\_ NO

g. IS THE PATIENT'S DISEASE REFRACTORY, OR HAS THE PATIENT RELAPSED AFTER 2 OR MORE LINES OF THERAPY? \_\_\_\_\_ YES \_\_\_\_\_ NO

h. DOES THE PATIENT HAVE PRIOR CENTRAL NERVOUS SYSTEM LYMPHOMA: \_\_\_\_\_ YES \_\_\_\_\_ NO

i. DOES THE PATIENT HAVE ADEQUATE BONE MARROW, CARDIAC, PULMONARY AND OTHER ORGAN FUNCTION: \_\_\_\_\_ YES \_\_\_\_\_ NO

j. DOES THE PATIENT HAVE A HISTORY OF ALLOGENIC STEM CELL TRANSPLANTATION: \_\_\_\_\_ YES \_\_\_\_\_ NO

i. IF YES, IS THERE ANY INDICATION OF GRAFT VS HOST DISEASE: \_\_\_\_\_ YES \_\_\_\_\_ NO

k. IS RENDERING PROVIDER/FACILITY CERTIFIED UNDER KYMRIA<sup>®</sup> OR YESCARTA<sup>™</sup> REMS SYSTEM PROGRAM: \_\_\_\_\_ YES \_\_\_\_\_ NO

PRESCRIBER ATTESTATION AND SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

**BY SIGNATURE, THE PRESCRIBER CONFIRMS S/HE IS AUTHORIZED TO PRESCRIBE THIS MEDICATION BY RI MEDICAID AND THE CRITERIA INFORMATION ABOVE IS ACCURATE, VERIFIABLE BY CLIENT RECORDS AND AVAILABLE FOR REVIEW UPON REQUEST.**

FOR STATE USE ONLY:

APPROVAL: \_\_\_\_\_ YES \_\_\_\_\_ NO PRIOR AUTHORIZATION #: \_\_\_\_\_ EFFECTIVE DATES: FROM: \_\_\_\_\_ TO \_\_\_\_\_