UTAH MEDICAID PHARMACY PRIOR AUTHORIZATION REQUEST FORM

Ryoncil (remestemcel-L-rknd)

Member and Medication Information * indicates required field	
*Member ID:	*Member Name:
*DOB:	*Weight:
*Medication Name/ Strength:	
☐ Do Not Substitute. Authorizations will be processed for the preferred Generic/Brand equivalent unless specified.	
*Directions for use:	
Provider Information * indicates required field	
*Requesting Provider Name:	*Requesting Prescriber NPI:
Address:	
*Contact Person:	*Office Phone:
*Office Fax:	*Office Email:
Medically Billed Information * indicates required field for all medically billed products	
*Diagnosis Code:	*HCPCS Code:
*Dosing Frequency:	*HCPCS Units per Dose:
Servicing Provider Name:	NPI:
Servicing Provider Address:	
Facility/Clinic Name:	NPI:
Facility/Clinic Address:	
Fax form and relevant documentation including: laboratory results, chart notes and/or updated provider letter to Pharmacy PA at **855-828-4992**, to prevent processing delays.	

Criteria for Approval: (*All* of the following criteria must be met)

1. Is the patient's age between 2 months to ≤ 17 years? ❑ **Yes** ❑ **No**
2. Does the patient have a diagnosis of Grade B-D steroid-refractory acute graft versus host disease (SR-aGvHD)? ❑ **Yes** ❑ **No**
    a. If the patient has Grade B, does the disease involve liver and/or gastrointestinal tract (GI)? ❑ **Yes** ❑ **No**
3. Is the medication being prescribed by a hematologist or oncologist? ❑ **Yes** ❑ **No**
4. Has the patient received methylprednisolone 2 mg/kg/day or equivalent for 7 consecutive days **AND** the aGvDG has progressed within 3 days or did not improve? ❑ **Yes** ❑ **No**
5. Does the patient have documented clinical rationale for non-use, trial and failure, intolerance, or contraindication to Jakafi (ruxolitinib)? ❑ **Yes** ❑ **No**
   Rationale: _____
6. What is the patient's anticipated treatment start date: _____

Reauthorization Criteria:

1. Choose the patient's response to the initial therapy:

	Patient's response to initial therapy	**Recommended treatment plan**
❑	Complete response	No further treatment with Ryoncil is recommended
❑	Partial or mixed response*	Repeat administration of Ryoncil once a week for additional 4 weeks (4 infusions total)
❑	Recurrence of GvHD after complete response	Repeat administration of Ryoncil twice a week for an additional 4 consecutive weeks (8 infusions total)
❑	No response	Consider alternative treatments

*Partial response is defined as organ improvement of at least one stage without worsening in any other organ, whereas mixed response was defined as improvement of at least one evaluable organ with worsening in another organ as per International Blood and Marrow Transplantation Registry Severity Index Criteria grading system.

Initial Authorization: Four (4) weeks from the anticipated start date

Reauthorization: Four (4) weeks from the anticipated restart date

Note:

- Use appropriate HCPCS code for billing:
  Coverage and Reimbursement code lookup: https://health.utah.gov/stplan/lookup/CoverageLookup.php
  HCPCS NDC Crosswalk: https://health.utah.gov/stplan/lookup/FeeScheduleDownload.php

PROVIDER CERTIFICATION

I hereby certify this treatment is indicated, necessary and meets the guidelines for use.

_____ _____

Prescriber's Signature Date

For ADA accommodation or assistance completing this form, please call us at 801-538-6155.