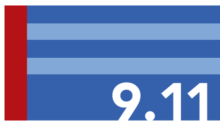

CAR-T Therapy Medical Expenses

Controlled Unclassified Information

Submission Instructions*:* Please refer to the CAR-T Therapy Medical Expenses Medical Coverage Determination (MCD) in the World Trade Center (WTC) Health Program Policy and Procedures Manual (PPM) when completing this form. Please apply the following naming convention for labeling the PA3 CAR-T Medical request PDF: PA3-CAR-T_Medical_[respective CCE/NPN]. Send completed form to the WTC Health Program by posting it to the secure SFTP server and then sending a Personally Identifiable Information (PII)-free e-mail to **WTCMedCode@csra.com**, indicating the secure server posting of this request. Incomplete forms will be sent back for more information. Please submit any additional documentation to support the medical necessity of this request.

Request Information

Request Date____________________ Request Type____________________

Date of Last Provider Visit____________________ Date of Last Authorization____________________

Date of Service____________________

Code (CPT, HCPCS, etc.) & Description

List the requested service, procedure and/or equipment code(s) and a description of each on the lines below.

____________________ ____________________

____________________ ____________________

____________________ ____________________

____________________ ____________________

____________________ ____________________

Member and Provider/Requester Information

Member Information

Last____________________ First____________________ MI__________

Date of Birth__________ Member #____________________ Member Type____________________

Provider Information

CCE/NPN____________________ Requesting Provider Name____________________

Requesting Provider Credentials____________________

Requesting Provider Email____________________

Requesting Provider Phone____________________ Requesting Provider Fax____________________

Criteria for CAR-T Therapy

Relevant WTC-Related and/or Medically Associated Certified Condition(s) and ICD Code(s)

______________________ ______________________

______________________ ______________________

Provider

The services are provided while the member is under the care of a WTC Health Program-affiliated provider.

Name______________________ Phone______________________

Facility

The services must be provided at an FDA-approved healthcare facility.

Name______________________ Location______________________

Attempted prior treatment(s), please specify

The member requires CAR-T Therapy due to relapse or failure of prior standard treatments.

Member enrolled in clinical trial Yes No

Acute Recovery Period Extension

This section is required for extension of the Acute Recovery Period coverage only. CAR-T Therapy services include coverage for monitoring and treatment up to 4 weeks (30 days) post CAR-T infusion. If additional monitoring and/or treatment is required beyond 30 days, coverage may be considered on a case-by-case basis for up to 14 days, for which a PA3 is required. A new PA3 is required for each extension up to 14 days.

Dates Requested

Beginning Date______________________ Ending Date______________________

Name and location of extended monitoring and/or treatment

Name______________________ Location______________________

Location Type Address

Clinical Summary

Please provide a clinical summary describing the medical necessity for the CAR-T Therapy services requested, detailed treatment plan as aligned with NCCN standards, and how the services relate to the treatment or management of the certified WTC-related condition and/or MAC. Coverage of CAR-T services is permitted only when in accordance with the Program formulary and other Program guidelines. Member may not be enrolled in a Clinical Trial Program.

Clinical Director Concurrence: I certify that this request and all associated documentation of policy requirements and medical necessity is being maintained in the member's medical record or other CCE/NPN tracking system. I also certify that these services are for the treatment and/or management of a certified WTC-related and/or medically associated health condition, and that the treatment/service(s) requested is/are non-experimental and non-investigational.

CCE/NPN Clinical Director Signature______________________________ **Date**________________

FOR NIOSH WTC HEALTH PROGRAM INTERNAL USE ONLY

Decision

Decision Comments

Required for NIOSH reviewer. If denied, provide clinical rationale and specific reasons for denial, outlining MCD criteria which were not met.

NIOSH Staff Signature____ **Date**_______________