



HUSKY Health Program RYONCIL® (remestemcel-L-rknd)
Prior Authorization Request Form
Phone: 1.800.440.5071

**THIS FORM IS TO BE COMPLETED BY THE ORDERING PROVIDER
AND FAXED WITH CLINICAL DOCUMENTATION TO 203.265.3994.**

Member Information			
Member ID #:		Member Name (Last, First):	
Address:		City, State, Zip:	
DOB:	Sex:	Primary Diagnosis Code:	
Date of Service:		HCPCS Code:	Dose:

Please fill out completely for all initial requests:			
1. Is the individual between two months and 17 years of age?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
2. Has the individual been diagnosed with grades B-D acute graft-versus-host disease (aGvHD) (excluding skin-only grade B) as defined by the International Blood and Marrow Transplantation Registry (IBMTR) severity index criteria grading system?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
3. Has the individual failed to respond to steroid treatment, defined as any grade B-D aGvHD that shows progression within three days, or no improvement within seven days of consecutive treatment with 2 mg/kg/day methylprednisolone or equivalent?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
4. Is RYONCIL® prescribed by or in consultation with a hematologist, oncologist, or a provider specializing in transplant medicine? If yes, please specify: Provider Name: _____ Phone Number: _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
5. Does the individual have adequate renal function as defined by a calculated creatinine clearance of >30 mL/min per 1.73 m ² ?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
6. Does the individual have a Karnofsky/Lansky Performance Level ≥30?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
7. Does the individual have a known hypersensitivity to dimethyl sulfoxide (DMSO) or porcine and bovine proteins?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
8. Does the individual have evidence of diffuse alveolar hemorrhage or other active pulmonary disease?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
9. Has the individual had a prior hematopoietic stem cell transplant for a solid tumor disease?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
10. Has the individual had prior treatment with mesenchymal stromal cells, including remestemcel-L-rknd?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
11. Does the individual have evidence of severe hepatic veno-occlusive disease or sinusoidal obstruction?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
12. Does the individual have evidence of encephalopathy, as defined by a change in mental status since the onset of aGvHD?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
13. Is the individual currently pregnant?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
14. Is the individual currently undergoing treatment for a solid tumor malignancy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
15. Will the treating provider follow all FDA-approved labeling for dosing, administration, and additional monitoring for RYONCIL®?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

Please fill out completely for all reauthorization requests:			
1. Has the individual demonstrated ONE of the following after an initial 28-day course of treatment with RYONCIL®? Please check which one applies: <input type="checkbox"/> A partial response to treatment defined as organ improvement of at least one stage without worsening of any other organ; OR <input type="checkbox"/> A mixed response to treatment defined as improvement of at least one evaluable organ with worsening in another organ per the IBMTR severity index criteria grading system.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

Billing Provider Information	
Medicaid Billing Number:	Billing Provider Name:
Street Address:	City, State, Zip:
Contact Name:	Contact Telephone Number:
Contact Fax Number:	

Ordering Provider Information	
Medicaid Billing Number:	Ordering Provider Name:
Street Address:	City, State, Zip:
Contact Name:	Contact Telephone Number:
Contact Fax Number:	Provider Specialty:

Certification Statement: This is to certify that the requested medication is medically indicated and is reasonable and necessary for the treatment of this patient, and that a prescribing practitioner signed order is on file. This form, and any statement on my letterhead attached hereto, has been completed by me or by my employee, and reviewed by me. The foregoing information is true, accurate, and complete, and I understand that any falsification, omission, or concealment of material fact may subject me to civil and criminal liability.	
Provider Signature:	Date: