Field Name	Field Description
Prior Authorization Group Description	**Blincyto**
Drugs	Blincyto (blinatumomab)
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	N/A
Required Medical Information	See "Other Criteria"
Age Restriction	N/A
Prescriber Restrictions	Prescriber must be an oncologist/hematologist
Coverage Duration	The request will be approved for up to a 12 month duration
Other Criteria Revision/Review Date 4/202**5**	****Drug is being requested through the member's medical benefit**** **Initial Authorization:** • Patient has a diagnosis of one of the following forms of Acute Lymphoblastic Leukemia (ALL): a) Relapsed CD19-positive B-cell precursor ALL b) Refractory CD19-positive B-cell precursor ALL **c**)B-cell precursor CD-positive ALL in first or second complete remission with minimal residual disease (MRD) greater than or equal to 0.1% **d) CD19-positive Philadelphia chromosome-negative B-cell precursor ALL in the consolidation phase of multiphase chemotherapy** • Provider attests to monitor patient for Cytokine Release Syndrome (CRS) and neurological toxicities **Reauthorization:** • Provider attests to treatment response or stabilization of disease • Prescriber attests to monitor patient for Cytokine Release Syndrome (CRS) and neurological toxicities **Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.**