# Funding request form:

## CAR-T treatment for cancer patients

**Please use this form to request Bupa funding for your patient to receive a MHRA (Medicines and Healthcare products Regulatory Agency) licenced CAR-T product for cancer.**

### What you need to do:

1. Complete all sections of this form including all relevant elements of your patient's current medical condition and medical history
2. Attach multidisciplinary team (MDT) notes about your patient
3. Attach your patient's relevant medical notes and most recent scans

**We can only agree funding if forms are complete and include relevant evidence. If we need to ask you for more information, this is likely to delay our funding decision and risks delaying your patient's treatment.**

## 1. Patient's details

| | |
|---|---|
| Title (please tick) | ☐ Miss ☐ Mrs ☐ Ms ☐ Mr ☐ Mx ☐ Dr ☐ Other (please state) |
| Name | |
| Date of birth | D D M M Y Y Y Y |
| Bupa membership or registration number | |

## 2. Clinician's details

| | |
|---|---|
| Name of requesting consultant | |
| Bupa provider number | Name of hospital or clinic |
| Phone number | Email address |

| | |
|---|---|
| Is the requesting consultant a haematologist accredited by the hospital or clinic for the use of this treatment? | ☐ Yes ☐ No |
| Is the hospital or clinic a Bupa recognised CAR-T provider? | ☐ Yes ☐ No |
| Is the consultant named in the hospital's or clinic's Bupa CAR-T agreement? | ☐ Yes ☐ No |

## 3. About the patient's general fitness

| | | |
|---|---|---|
| Does the patient have an ECOG performance score of 0 or 1? | ☐ Yes | ☐ No |
| Does the patient have a known history or current evidence of central nervous system (CNS) involvement? | ☐ Yes | ☐ No |
| Does the patient have a history of Parkinson's disease or other neurogenerative disorder? | ☐ Yes | ☐ No |
| Does the patient have a creatinine clearance (as estimated by Cockcroft Gault) ≥ 60 mL/min? | ☐ Yes | ☐ No |
| Does the patient have a serum ALT/AST ≤ 2.5 ULN? | ☐ Yes | ☐ No |
| Does the patient have a total bilirubin ≤1.5 mg/dl? | ☐ Yes | ☐ No |

| | | |
|---|---|---|
| Does the patient have a cardiac ejection fraction ≥ 50% with no evidence of pericardial effusion as determined by an echocardiogram (ECHO)? | ☐ Yes | ☐ No |
| Does the patient have any clinically significant electrocardiogram (ECG) findings? | ☐ Yes | ☐ No |
| Does the patient have evidence of unstable angina and/or myocardial infarction within the past six months? | ☐ Yes | ☐ No |
| Does the patient have a baseline oxygen saturation >92% on room air? | ☐ Yes | ☐ No |
| Does the patient have clinically significant pleural effusion? | ☐ Yes | ☐ No |
| Has the patient been screened for hepatitis B (HBV), hepatitis C (HCV) and human immunodeficiency virus (HIV) and has no evidence of these infections? | ☐ Yes | ☐ No |
| Does the patient have any other active infections or inflammatory disorders (including pneumonitis and myocarditis)? (If yes please provide details) | ☐ Yes | ☐ No |
| Will the appropriate dose(s) of tocilizumab be available for use in this patient if they develop cytokine release syndrome? | ☐ Yes | ☐ No |
| Does the patient have adequate end organ function to tolerate CAR-T treatment? | ☐ Yes | ☐ No |

# 4. The patient's treatment to date

## Past cancer treatment

Has the patient had treatment with any genetically modified autologous or allogeneic T cell immunotherapy before? ☐ *Yes ☐ No
*If yes, please give details below.

| Line of treatment | Drug regimen | Treatment response | Number of cycles | Treatment start date | Date of relapse |
|---|---|---|---|---|---|
| First | | | | D D M M Y Y | D D M M Y Y |
| Second | | | | D D M M Y Y | D D M M Y Y |
| Third | | | | D D M M Y Y | D D M M Y Y |
| Fourth | | | | D D M M Y Y | D D M M Y Y |
| Other(s) | | | | D D M M Y Y | D D M M Y Y |

Please list all current medication, contraindications and allergies

# 5. About the treatment

Which CAR-T product is intended for this patient?

| | | | | | |
|---|---|---|---|---|---|
| ☐ Abecma | ☐ Carvykti | ☐ Tecartus | ☐ Kymriah | ☐ Yescarta | ☐ Breyanzi |
| ☐ Other | State name: | | | | |

Proposed treatment start date ☐D ☐D ☐M ☐M ☐Y ☐Y

What is the proposed bridging therapy?

What is the proposed lymphodepletion therapy?

| | | |
|---|---|---|
| Have all treatment options (including NHS CAR-T treatment if applicable) and locations been discussed with the patient? | ☐ Yes | ☐ No |
| If applicable to the intended product, has the patient been made aware that there are no clinical differences in the delivery of, and priority of access to, CAR-T treatment based on whether the treatment is funded privately or provided by the NHS? | ☐ Yes | ☐ No |
| Has provision of the CAR-T product been confirmed with the manufacturer? | ☐ Yes | ☐ No |

Please complete the relevant section below for the condition being treated

## Acute lymphoblastic leukaemia (ALL)

| | | |
|---|---|---|
| Does the patient have relapsed or refractory B-cell precursor ALL? | ☐ Yes | ☐ No |
| Is the patient relapsed or refractory following a stem cell transplant or in second or later relapse? | ☐ Yes | ☐ No |
| Does the patient have an isolated extramedullary ALL relapse? | ☐ Yes | ☐ No |
| Has the patient been treated with blinatumomab or an anti-CD-19 antibody? | ☐ Yes | ☐ No |

## B-cell lymphomas - Diffuse large B cell lymphoma (DLBCL), Primary mediastinal B cell lymphoma (PMBCL), High-grade B-Cell lymphoma (HGBL)

| | | |
|---|---|---|
| Has progressive disease been defined radiologically as per RECIST version 1.1 and is this based on CT or MRI scans? | ☐ Yes | ☐ No |
| Has the disease relapsed within 12 months from completion of or refractory to first line chemoimmunotherapy? | ☐ Yes | ☐ No |
| Has the patient had two or more lines of systemic therapy? | ☐ Yes | ☐ No |

## Mantle Cell Lymphoma (MCL)

| | | |
|---|---|---|
| Has relapsed or refractory MCL been confirmed? | ☐ Yes | ☐ No |
| Has the patient had two or more lines of systemic treatment including a Bruton's tyrosine kinase (BTK) inhibitor? (e.g Acalabrutinib (Calquence)/ Zanbrutinib (Brukinsa) | ☐ Yes | ☐ No |

## Follicular Lymphoma (FL)

| | | |
|---|---|---|
| Has relapsed/refractory follicular lymphoma been confirmed? | ☐ Yes | ☐ No |
| Is the follicular lymphoma grade 3B (FL3B)? | ☐ Yes | ☐ No |
| If treatment with Yescarta is planned, has the patient previously been given three or more lines of systemic therapy? | ☐ Yes | ☐ No |
| If treatment with Kymriah is planned, has the patient previously been given two or more lines of systemic therapy? | ☐ Yes | ☐ No |
| If treatment with Breyanzi is planned, has the patient previously been given one (if relapsed or refectory within 12 months of completion), or two or more lines of systemic therapy? | ☐ Yes | ☐ No |

## Multiple Myeloma (MM)

| | | |
|---|---|---|
| Has relapsed or refractory BCMA Multiple Myeloma been confirmed as per the International Myeloma Working Group (IMWG) criteria? | ☐ Yes | ☐ No |
| Have any BCMA targeted therapies been administered before (e.g Teclistamab)? | ☐ Yes | ☐ No |
| Are there clinical signs of meningeal involvement of multiple myeloma? | ☐ Yes | ☐ No |

## 5. About the treatment (continued)

| | | |
|---|---|---|
| If treatment with Abecma is planned, has the patient been treated with at least two previous treatment regimens that have consisted of an immunomodulatory agent (eg Lenalidomide), a proteasome inhibitor (eg Bortezomib) and an anti-CD38 antibody (eg Daratumumab), and have demonstrated disease progression? | ☐ Yes | ☐ No |
| If treatment with Abecma is planned, have at least four months passed since an allogenic stem cell transplant? | ☐ Yes | ☐ No |
| If treatment with Carvykti is planned, have at least six months passed since an allogenic stem cell transplant? | ☐ Yes | ☐ No |
| If treatment with Carvykti is planned, has the patient been treated with at least one line of therapy including an immunomodulatory agent and proteasome inhibitor? | ☐ Yes | ☐ No |
| If treatment with Carvykti is planned, is the patient refractory to lenalidomide? | ☐ Yes | ☐ No |

## 6. Supporting evidence

Please tick the boxes below to confirm that you've sent the following reports, including medical notes, to Bupa as part of this CAR-T funding request.

| | |
|---|---|
| Patient's MDT notes (see appendix) | ☐ |
| Medical report including:<br>▪ Diagnosis and stage of cancer<br>▪ Previous and current cancer treatment<br>▪ Co-morbidities<br>▪ Allergies and performance status<br>▪ Family history or previous genetic testing<br>▪ Palliative care information if relevant | ☐ |
| Pulmonary function test (necessary where the patient has poor lung or cardiac function) | ☐ |
| Pathology including full blood count, biochemistry, liver function, viral screening, lactate dehydrogenase tests and ferritin levels. | ☐ |
| Imaging reports (most recent) including ECG, ECHO, PET scans and brain MRI if there is central nervous system involvement. | ☐ |

## 7. Consultant's declaration

**I confirm that the information on this form is accurate, that I've obtained informed consent from the patient and explained all the risks and alternatives associated with this treatment.**

I understand that the clinical information I've supplied may be considered to be a medical report for insurance purposes. I confirm that my patient (or their legal representative) has given their permission for me to share this information and, where they've asked to review this information, they've been given an opportunity to do so before I submitted this form.

Consultant's name

Date D D M M Y Y Y Y

General Medical Council number

### Further information

Please email your completed form and supporting information to us by secure email: **specialistnursesupport@bupa.com**

Information you send to this email address may not be secure unless you send us your email through Egress. To sign up for a free Egress account, go to **https://switch.egress.com**

We'll let you know by phone or secure email within seven working days of receiving your completed form whether your Bupa patient's treatment is covered by their policy or scheme.

Please let us know how you'd prefer us to contact you about this.

Phone ☐ Secure email ☐

What's the best phone number or email address for us to use?

If you've any questions, please call us on **0845 850 0465** between 8am and 6pm Monday to Friday and we'll be happy to help. We may record or monitor our calls.

# 8. Appendix

## MDT requirements for Bupa CAR-T network hospitals

Before we can let you know whether your patient's proposed CAR-T treatment is covered by their policy or scheme, their case needs to be reviewed by an MDT at a Bupa CAR-T Network hospital or clinic to endorse clinical eligibility and prioritisation.

Bupa CAR-T network hospital MDTs need to be quorate and include sufficient representation from the following:

- At least two haemato-oncologists (either haematologists or medical oncologists) who specialise in your patient's tumour type being discussed, one from each hospital contributing to the MDT.
- At least one haematopathologist from the Specialist Integrated Haematological Malignancy Diagnostic Services to provide the diagnostic information.
- Input from the clinical oncologist, as required, when radiotherapy is delivered for your patient.
- At least one radiologist specialising in haematology or lymphoma and input from neuro-radiology as required.
- At least one clinical nurse specialist acting as your patient's advocate and accountable for ensuring that frailty is taken into account and documented.
- At least one specialist palliative care doctor on the specialist register or a nurse experienced in palliative care to liaise with specialists from other sites
- At least one geriatrician if your patient is over the age of 65.
- A neurologist if your patient has significant neurological comorbidities.
- A cardiologist if your patient has significant cardiology comorbidities.
- Support staff to organise team meetings, provide secretarial support and submit all required documents to Bupa.

In line with our contract, we may need a peer review process to take place to confirm the patient's clinical suitability for CAR-T treatment.



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