Review instructions below to complete both the Provider Survey and Team Table via the online web application BD Portal.

<table>
<thead>
<tr>
<th>Part 1: Provider Survey</th>
<th>Question Numbers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Information</td>
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</tr>
<tr>
<td>CAR-T Therapy Program Information</td>
<td>3 - 28</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Part 2: Team Table</th>
<th>Question Numbers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Team Table</td>
<td>Part 2</td>
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<tr>
<td>Attestation</td>
<td>Part 2</td>
</tr>
</tbody>
</table>

**PART 1: PROVIDER SURVEY**

This Provider Survey supports the quality based evaluation process for the Blue Distinction Centers for Cellular Immunotherapy – CAR-T Therapy designation. All information in this application pertains to your current and active chimeric antigen receptor cell therapy (CAR-T) program, referred to as ‘CAR-T program.’ Please be sure that your application is complete before submitting.

Facilities must submit an electronic version of Part 1: Provider Survey AND Part 2: Team Table in BD Portal for a complete submission.

Additional program materials for the Blue Distinction Centers for Cellular Immunotherapy – CAR-T Therapy designation are available at: www.bcbs.com

**PROVIDER INFORMATION**
PROVIDER ADDRESS AND IDENTIFIERS WILL BE PRE-POPULATED IN THE ONLINE VERSION OF THIS SURVEY.

PROVIDER NAME:
ADDRESS:
CITY:
STATE:
ZIP:

If any of the Provider information shown above is incorrect, please email BDCAdmins@bcbsa.com or contact your local Blue Cross and/or Blue Shield Plan directly to have the information corrected.

Also, please review your National Provider Identifier (NPI), Federal Tax Identification Number (FEIN), and CMS Certification Number (CMS ID) on your Provider Record in BD Portal, to confirm accuracy. To access your Provider Record, click on your provider name on the Survey Actions tab in BD Portal.

If any of the provider identifiers shown on the Details sub-tab are incorrect, please email BDCAdmins@bcbsa.com or contact your local Blue Cross and/or Blue Shield Plan directly to have the information corrected.

1. Please provide the following information for the person responsible for completing and submitting this Provider Survey:

   **Primary Contact**
   Name:
   Title:
   Phone:
   Email:

2. Please provide your facility’s legal contact. This individual may be contacted in the event there are questions related to potential brand conflicts that need to be addressed.

   **Legal Counsel/Representative Contact:**
   Name:
   Title:
   Phone:
   Email:
Questions in this section that refer to “my,” “your,” “my program’s” or “your program” all refer to your Facility’s own CAR-T program (not the Blue Distinction Centers for Cellular Immunotherapy -- CAR-T program).

“CAR-T Episode of Care,” as used herein, includes: (1) pre-CAR-T therapy, which begins with leukapheresis; (2) conditioning for CAR-T therapy, which occurs prior to initiation of CAR-T cell infusion; (3) CAR-T cell infusion, acute phase recovery, monitoring, and management, for 30 days after CAR-T cell infusion; and (4) monitoring outcomes, managing any complications, and providing ongoing support during later phase follow up.

“CAR-T Episode of Care” pertains to CAR-T therapy using either of the currently FDA-approved products (Kymriah® or Yescarta®).

Program Structure/Process Information

3. Is your facility accredited through the Foundation for the Accreditation of Cellular Therapy (FACT), including Standards for Immune Effector Cells?
   - YES  ☐  NO  ☐

4. Does your program deliver coordinated multidisciplinary care, including facilitating timely access to quality medical and psychosocial care, throughout the CAR-T Episode of Care?
   - YES  ☐  NO  ☐
   - Select all that apply:
     - YES, for Relapsed/Refractory B-cell precursor acute lymphoblastic leukemia (ALL) for patients up to 25 years of age
     - YES, for Relapsed/Refractory large B-cell lymphoma (DLBCL) for adults
     - NO  ☐

5. Does your program deliver efficient, appropriate, and effective flow of necessary patient care information to providers and patients (e.g., use of EHR and patient portal)?
   - YES  ☐  NO  ☐

6. Does your program deliver care planning, by managing patients throughout all stages of treatment during the CAR-T Episode of Care?
   - YES  ☐  NO  ☐
   - Select all that apply:
     - YES, for Relapsed/Refractory B-cell precursor acute lymphoblastic leukemia (ALL) for patients up to 25 years of age
     - YES, for Relapsed/Refractory large B-cell lymphoma (DLBCL) for adults
     - NO  ☐
7. Does your program facilitate multidisciplinary care (either within an integrated delivery system or through coordination within a virtually organized ‘medical neighborhood’ delivery system), to ensure that the patient has access to all of the following disciplines: medical oncology; nursing/ oncology nursing; palliative care; diagnostic radiology; pathology; genetic counseling; social work/ psychological support; and rehabilitation?

☐ YES  ☐ NO

8. Does your program ensure enhanced care access (open access scheduling; expanded hours; and new options for communication between patient and practice) to support urgent patient needs?

☐ YES  ☐ NO (Skip to question 10)

9. If ‘YES’, please describe your program’s enhanced care access, including information on whether there is a direct line or responsible provider for urgent patient access.

10. Has your program implemented patient-centered care, by including patient/family in planning and goal setting, as well as managing symptoms, with the goal to improve the quality of life for both the patient and the family?

☐ YES  ☐ NO (Skip to question 12)

11. If ‘YES’, please describe how your program implements patient-centered care.

12. Does your program follow standard practices and monitoring for safe administration of chemotherapy?

☐ YES  ☐ NO

13. Does your program commit to system-wide monitoring and reporting of CAR-T patients through the CIBMTR registry, AND to report requested quality measures to BCBSA to support designation evaluation?

☐ YES  ☐ NO

14. Does your program incorporate measurement results into feedback and quality improvement of the CAR-T system of care?

☐ YES  ☐ NO (Skip to question 16)

15. If ‘YES’, please describe your program’s quality improvement program and the measures included in it.
16. Does your program engage patient/family in a Shared Decision Making process (defined below) for goal setting and treatment planning that provides information on realistic expectations and impacts of treatment options, through use of appropriate tools, so that care delivers utility to the patient?

**Shared Decision Making**

- Shared Decision Making is an approach where clinicians and patients consistently discuss all reasonable treatment options, the benefits and harms of those options, and which benefits and harms matter most to the patient, in order to jointly make treatment decisions that are consistent with both the best medical evidence and the patient’s preferences.
- Patient-Centered Shared Decision Making aids (e.g., booklet, video) are tools that help people become involved in decision making, by providing information about the options and outcomes and by clarifying personal values. They are designed to complement, rather than replace, counseling from a health care professional.
- One key to success lies in training physicians to help them understand how to facilitate the Shared Decision Making process and to ensure that they appreciate the importance of respecting patient’s values, preferences, and expressed needs. ¹ ² It is also helpful to use a team approach to Shared Decision Making so that the physician’s time is used appropriately.


☐ YES ☐ NO (Skip to question 18)

17. If ‘YES’, please describe how your program implements Shared Decision Making.

18. Does your program participate in a standardized Patient Satisfaction and Experience Survey to evaluate and improve care delivery?

☐ YES ☐ NO (Skip to question 20)

19. If ‘YES’, please describe the Patient Satisfaction and Experience Survey used by your program.

**Program Certification and Volume Information**

20. Is your program certified to provide CAR-T therapy through **at least one** of the following programs? Select all that apply.

☐ Novartis REMS program *(if checked, complete questions 21 and 22)*
☐ Kite REMS program *(if checked, complete questions 23 and 24)*

☐ My facility is not currently certified to provide CAR-T therapy by either of the programs listed. *(Skip to question 25)*
Novartis REMS Program – Kymriah®

21. Please report the volume of CAR-T therapies that your facility has performed, at all times to date.

Note: Only enter zero (0) if the reported volume is zero (0). If the program is unable to report or does not have the volume information requested, choose the radio button indicating that the program is ‘unable to report’.

<table>
<thead>
<tr>
<th>Indications for Kymriah® Treatment</th>
<th>CAR-T Therapy Volumes</th>
</tr>
</thead>
<tbody>
<tr>
<td>FDA Approved: Relapsed/Refractory B-cell precursor acute lymphoblastic leukemia (ALL) for patients up to 25 years of age.</td>
<td>✧ Unable to report</td>
</tr>
<tr>
<td>FDA Approved: Relapsed/Refractory large B-cell lymphoma for adults</td>
<td>✧ Unable to report</td>
</tr>
<tr>
<td>Other investigational indication(s) that are part of a clinical trial for adults and/or pediatric patients</td>
<td>✧ Not Applicable</td>
</tr>
</tbody>
</table>

* Web link for FDA approval for Kymriah

22. How many months are you using to report the volume of CAR-T therapies for your facility in the table above?

Kite REMS Program – Yescarta®

23. Please report the volume of CAR-T therapies that your facility has performed, at all times to date.

Note: Only enter zero (0) if the reported volume is zero (0). If the program is unable to report or does not have the volume information requested, choose the radio button indicating that the program is ‘unable to report’.

<table>
<thead>
<tr>
<th>Indication for Yescarta® Treatment</th>
<th>CAR-T Therapy Volume</th>
</tr>
</thead>
<tbody>
<tr>
<td>FDA Approved: Relapsed/Refractory large B-cell lymphoma for adults</td>
<td>✧ Unable to report</td>
</tr>
<tr>
<td>Other investigational indication(s) that are part of a clinical trial for adults and/or pediatric patients</td>
<td>✧ Not Applicable</td>
</tr>
</tbody>
</table>

* Web link for FDA approval for Yescarta

24. How many months are you using to report the volume of CAR-T therapies for your facility in the table above?

25. Does your facility have dedicated inpatient beds that are used for CAR-T therapy?

☐ YES  ☐ NO (Skip to question 27)

26. If ‘YES’, please describe your program’s facility and staff capacity to manage CAR-T patients, as inpatients (e.g., number of beds and nurse–to-patient ratio).
27. Does your facility have an outpatient infusion center or specialty clinic that is used to provide CAR-T Therapy on an outpatient basis?
   □ YES □ NO (Skip to Part 2 – Team Table and Attestion)

28. If ‘YES’, please describe your program’s capacity to manage CAR-T patients, as outpatients.

NOTE: In addition to Part 1: Provider Survey, each facility must also complete Part 2: Team Table via the Survey Actions tab in BD Portal to complete the application.
### PART 2: TEAM TABLE

**Physician Team Table**

Please complete the Team Table for **ALL** Physicians who are currently providing CAR-T therapy care to cancer patients at your facility.

- Exclude all Physicians who are not currently practicing at your facility at the time of this application’s submission (i.e., retired, left employment).
- Exclude all Physicians who do not provide CAR-T therapy to cancer patients.
- Exclude locum tenant Physicians.
- Exclude Physician Assistants, Nurse Practitioners, or Medical/Surgical Residents in training.

There are **two options** to complete the requested information:

**Option 1** – Download an Excel template to enter Physician names and upload the template to automatically populate the Team Table

**OR**

**Option 2** – Manually enter each Physician name (one at a time) using the form below.

#### Option 1 – Download and Upload Template

**Step 1** - Click Download Template and open the file in Excel. Complete a row for each Physician; make sure the ‘Type’ column contains only the word ‘Physician.’ Save the completed Excel spreadsheet as a CSV file to your computer, as you will need to upload it into BD Portal in Step 2.

**Step 2** - Browse your computer to locate the saved Excel CSV file.

**Step 3** - Once you have located the saved Excel file on your computer, click the ‘Upload Template’ button.

*Note:* Uploading a template will over-write existing information in the table below.

#### Option 2 – Manually Enter Using Form

**Step 1** - Manually enter Physician information into the form below.

**Step 2** - Click the ‘Save’ button to update the Physician Team Table. Repeat as necessary until all Physicians are added to the Team Table below.
Physician Team Table

<table>
<thead>
<tr>
<th>FIRST NAME</th>
<th>LAST NAME</th>
<th>TYPE 1 NATIONAL PROVIDER IDENTIFIER (NPI)</th>
<th>SURGEON OR PHYSICIAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
</tr>
</tbody>
</table>
Terms & Conditions

Attestation for Provider Survey Participation
Blue Distinction® Centers for Specialty Care Program(s)

By submitting its response to this Provider Survey for consideration as a participant in this Blue Distinction Centers for Specialty Care® Program(s) (the “Program(s)”), and, if accepted by BCBSA, as a condition to any designation and participation in the Program(s), this provider (“Provider”) represents and agrees as follows:

1. All information that Provider provides in its response to BCBSA's Provider Survey for consideration as a participant in this Program(s) (including information provided in Provider's initial response, as well as any additional materials submitted throughout the evaluation and appeal process for this Provider Survey cycle) is and will be true and complete, as of the date Provider provides such information to BCBSA. Provider will advise BCBSA immediately of any material change in such information during this Provider Survey process, and if Provider is designated as a Blue Distinction Center under this Program(s), for the duration of such designation.

2. BCBSA may share Provider's individual Provider Survey responses (“Raw Data”) and results (“Scores”) with BCBSA's member Plans and, pursuant to a confidentiality agreement, member Plans' current and prospective accounts, for purposes of evaluation, care management, quality improvement, and member Plans' design of customized products and networks. BCBSA may combine Provider's Raw Data and Scores together with other Providers' data to create aggregate information for public dissemination, provided that such aggregate information will not identify Provider by name, and will not contain any Protected Health Information (“PHI”), as defined under the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations (45 C. F. R. Parts 160-164). Provider's Raw Data and Scores will not be publicly disseminated beyond the extent permitted above without Provider's prior written consent, unless required by law (e.g., subpoena).

3. Neither Provider nor any entity in which Provider holds a controlling interest uses or intends to use in a logo any cross or shield design (or design that gives the commercial impression of a cross or shield) that contains the color blue (or that gives the commercial impression of the color blue), or any other name, mark, or design logo that is confusingly similar to or dilutes the BLUE CROSS or BLUE SHIELD word or design trademarks, or any other trademarks owned by BCBSA.