UTAH MEDICAID PHARMACY PRIOR AUTHORIZATION REQUEST FORM

Casgevy (exagamglogene autotemcel)

Member and Medication Information * indicates required field	
*Member ID:	*Member Name:
*DOB:	*Weight:
*Medication Name/ Strength:	
☐ Do Not Substitute. Authorizations will be processed for the preferred Generic/Brand equivalent unless specified.	
*Directions for use:	
Provider Information * indicates required field	
*Requesting Provider Name:	*Requesting Prescriber NPI:
Address:	
*Contact Person:	*Office Phone:
*Office Fax:	*Office Email:
Medically Billed Information * indicates required field for all medically billed products	
*Diagnosis Code:	*HCPCS Code:
*Dosing Frequency:	*HCPCS Units per Dose:
Servicing Provider Name:	NPI:
Servicing Provider Address:	
Facility/Clinic Name:	NPI:
Facility/Clinic Address:	
Fax form and relevant documentation including: laboratory results, chart notes and/or updated provider letter to Pharmacy PA at **855-828-4992**, to prevent processing delays.	

Criteria for Approval: (*All* of the following criteria must be met)

1. Is the patient at least 12 years of age or older? ❑ **Yes** ❑ **No**
2. Does the patient have a confirmed diagnosis of one of the following? ❑ **Yes** ❑ **No**
   - ☐ Sickle cell disease, with recurrent vaso-occlusive crises (VOCs) defined as history of ≥2 VOCs annually within the past 2 years
   - ☐ Transfusion-dependent β-thalassemia
     - The patient has a history of requiring at least 100mL/kg/year or 10 units/year of Red Blood Cell (RBC) transfusion in the past 2 years
3. Is the patient seropositive for Human Immunodeficiency Virus, Hepatitis B Virus or Hepatitis C Virus? ❑ **Yes** ❑ **No**
4. Has the patient received prior treatment with any gene therapy for sickle cell disease or β-thalassemia and is not being considered for treatment with any other gene therapy for sickle cell disease or β-thalassemia? ❑ **Yes** ❑ **No**
5. Has the patient has not had any previous Hematopoietic Stem Cell Transplant (HSCT) ❑ **Yes** ❑ **No**
6. Does the provider attest to the following? ❑ **Yes** ❑ **No**
   - ☐ Confirmation that autologous hematopoietic stem cell transplantation is appropriate for the patient

- ☐ Infectious diseases screening will be performed in accordance will clinical guidelines prior to cell collection for manufacturing
- ☐ Anti-retroviral medications will be discontinued at least 1 month prior to mobilization and until all cycles of apheresis are completed
- ☐ Hydroxyurea and other disease-modifying agents will be discontinued at least 2 months prior to mobilization and conditioning
- ☐ Iron chelation will be discontinued at least 7 days prior to mobilization and conditioning
- ☐ Discussion about the risk/benefit of the therapy including fertility preservation, reproductive consultation, and teratogenicity with the patient

7. Has the patient tried and failed or has an intolerance to, or a contraindication to hydroxyurea for at least 4 months or one other disease-modifying pharmacologic agent (eg, L-glutamine, voxelotor)? ❑ **Yes** ❑ **No**
   Medication: ______________________ Details: ____

Initial Authorization: One-time single dose only

Note:

- ❖ Use appropriate HCPCS code for billing:
  Coverage and Reimbursement code lookup: https://health.utah.gov/stplan/lookup/CoverageLookup.php
  HCPCS NDC Crosswalk: https://health.utah.gov/stplan/lookup/FeeScheduleDownload.php

PROVIDER CERTIFICATION

I hereby certify this treatment is indicated, necessary and meets the guidelines for use.

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Prescriber's Signature Date