UTAH MEDICAID PHARMACY PRIOR AUTHORIZATION REQUEST FORM

Lyfgenia (lovotibeglogene 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 diagnosis of sickle cell disease? ❑ **Yes** ❑ **No**
3. Is the medication being prescribed by OR in consultation with a hematologist that is specialized in sickle cell disease? ❑ **Yes** ❑ **No**
4. Does the patient have a documented history of vaso-occlusive events (VOEs) defined as history of ≥4 VOEs within the past 2 years? ❑ **Yes** ❑ **No**
5. Is the patient seropositive for Human Immunodeficiency Virus? ❑ **Yes** ❑ **No**
6. Has the patient received prior treatment with any gene therapy for sickle cell disease or being considered for treatment with any other gene therapy for sickle cell disease? ❑ **Yes** ❑ **No**
7. Has the patient had any previous Hematopoietic Stem Cell Transplant (HSCT)? ❑ **Yes** ❑ **No**
8. Does the provider attest to the following? ❑ **Yes** ❑ **No**
   - ☐ Confirmation that autologous hematopoietic stem cell transplantation is appropriate for the patient
   - ☐ Perform screening for infectious disease in accordance with clinical guidelines before collection of cells for manufacturing
   - ☐ Discontinue anti-retroviral medications at least 1 month prior to mobilization and until all cycles of apheresis are completed

- ☐ Discontinue hydroxyurea and other disease-modifying agents at least 2 months prior to mobilization and conditioning
- ☐ Discontinue iron chelation 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

9. Has the patient tried and failed or has an intolerance to, or contraindication to hydroxyurea for at least 4 months or one other disease-modifying pharmacologic agent (eg., L-glutamine, voxelotor, crizanlizumab)?

❑ Yes ❑ No

Medication: _____ Details: _____

Initial Authorization: One-time single dose only

Note:

- ❖ Hematologic malignancy has occurred in patients treated with Lyfgenia. Recommend to monitor patients closely for evidence of malignancy through complete blood counts at least every 6 months and through integration site analysis at months 6, 12, and as warranted.
- ❖ 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.

_____ _____

Prescriber's Signature Date