Betibeglogene Autotemcel (Zynteglo)

Prior Authorization Form/Prescription

Telephone: (800) 514-0083 option 2
Fax: (866) 374-1579

Date: __________ Date Medication Required: __________
Ship to: ❍ Physician ❍ Patient's Home ❍ Other

Patient Information

*Last Name:	*First Name:	Middle:	*DOB: ____/____/____
Daytime Phone:	Evening Phone:	*Sex: ☐ Male ☐ Female	

Insurance Information (*Attach copies of cards*)

*Primary Insurance:		Secondary Insurance:	
*ID #:	Group #:	ID #:	Group #:

Physician Information

*Name:	*Specialty:	NPI:
*Phone #:	Secure Fax #:	Office Contact:

Procedural Hospital

*Hospital Name:

Primary Diagnosis

*ICD-10 Code: ______________________________

☐β-thalassemia ☐Other: ____________________

Prescription Information

MEDICATION	STRENGTH	*DIRECTIONS	QUANTITY	REFILLS
Zynteglo (Betibeglogene Autotemcel)				

Clinical Information

***** *Please submit supporting clinical documentation* *****

***THERAPY TYPE (choose one):** ☐INITIAL THERAPY ☐CONTINUATION OF THERAPY

Therapy start date: __________

1. Is therapy prescribed by or in consultation with a hematologist and transplant specialist? ☐Yes ☐No
2. Is β-thalassemia with genetic confirmation (β-thalassemia genotype)? ☐Yes ***Mark all that apply*** ☐No
   ☐β^0/β^0 ☐β^0/β^+ ☐β^+/β^+ ☐β^E/β^0 ☐β^+ IVS1-110/β^+ IVS1-110 ☐β^0/β+ IVS1-110 ☐Other: ______________
3. Please provide patient's weight: ______________ kg
4. Is there documentation of 1 of the following per year in the 2 previous years? ☐Yes ***Mark all that apply*** ☐No
   ☐Receipt of ≥ 8 transfusions of packed red blood cells (pRBC*) ☐Receipt of ≥ 100 mL/kg pRBC*
   **1 RBC unit refers to a quantity of pRBC approximately 200-350 mL*
5. Is there attestation from transplant specialist for both of the following? ☐Yes ***Mark all that apply*** ☐No
   ☐Patient understands the risks and benefits of alternative therapeutic options such as allogenic hematopoietic stem cell transplantation (HSCT)
   ☐Patient is clinically stable and eligible to undergo myeloablative conditioning and HSCT
6. Has patient previously received allogenic HSCT or gene therapy? ☐Yes ☐No
7. Does patient have advanced liver disease? ☐Yes ***Mark all that apply*** ☐No
   ☐Cirrhosis ☐Active hepatitis ☐Bridging fibrosis ☐Fatty liver disease ☐Other: ______________
8. Is patient positive for the presence HIV type 1 or 2? ☐Yes ☐No
9. Does patient have any prior or current malignancy? ☐Yes ☐No
10. How many Zynteglo infusions has patient receive in their lifetime? ☐0 ☐1 or more
11. **If patient age ≥ 5**, is there medical rational that patient is anticipate to be able to provide at least the minimum number of cells required to initiate the manufacturing process? ☐Yes ***Provider must submit documentation*** ☐No

Complete this section ONLY for indications other than β-thalassemia:

12. Has patient tried and failed, or is contraindicated to, accepted standards of care? ☐Yes ☐No
    If yes, submit documentation and answer the following:
    a. Please list all previous therapies: ______________________________
    b. Was patient adherent to previously tried therapies? ☐Yes ☐No ☐No, patient intolerant to drug

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Please continue to page 2.

Patient Name: ______________________________ **DOB:** ______________

Physician's Signature ______________________________ **Date:** ____________ ☐ **DAW**

INFORMATION BELOW IS TO BE COMPLETED BY THE HEALTH PLAN / CPS PA STAFF

Authorization Information

***Authorization number**:	***Decision Due Date**:
***J-Code**:	**Coverage**: ☐State excludes ☐COB (secondary)
***Line of Business**: ☐Commercial ☐Health Insurance Marketplace ☐Medicaid ☐Medicare	***Benefit**: ☐Medical ☐Pharmacy

***Choose one criteria option below based on line of business**:

Medicare Criteria Only:

☐Medicare Local Coverage Decision (LCD) specific for your region.
Please include policy of link to LCD, followed by any applicable Medicare Part B step therapy requirements in MCPB.ST.00

☐Medicare National Coverage Decision (NCD).
Please include policy of link to NCD, followed by any applicable Medicare Part B step therapy requirements in MCPB.ST.00

***Medicaid, Commercial, Exchange (Ambetter) Criteria:**

☐Centene Policy [**CP.PHAR.545 Betibeglogene autotemcel (Zynteglo)]**
Date Policy last reviewed/approved by plan (we want to be sure we are using the version approved by your plan): ____________

OR

☐State or Health Plan Specific (please include policy)