

**Zynteglo® (betibeglogene autotemcel) Prior Authorization Form**

**Member Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_ **Member ID#:** \_\_\_\_\_

**Drug Information**

**Physician billing (HCPCS code:** \_\_\_\_\_ **) Start Date:** \_\_\_\_\_

**Billing Provider Information**

**Provider NPI:** \_\_\_\_\_ **Provider Name:** \_\_\_\_\_

**Provider Phone:** \_\_\_\_\_ **Provider Fax:** \_\_\_\_\_

**Prescriber Information**

**Prescriber NPI:** \_\_\_\_\_ **Prescriber Name:** \_\_\_\_\_

**Prescriber Phone:** \_\_\_\_\_ **Prescriber Fax:** \_\_\_\_\_ **Specialty:** \_\_\_\_\_

**Criteria**

**For Authorization: (Only one Zynteglo® infusion will be approved per member per lifetime):**

1. Please indicate the member's diagnosis:
  - Beta Thalassemia
  - Other: \_\_\_\_\_
2. Does the member require regular red blood cell (RBC) transfusions as demonstrated by one of the following?
  - History of ≥100mL/kg/year transfusions of packed RBCs in the last 2 years.
    - i. Dates of occurrence: \_\_\_\_\_
  - ≥8 transfusions of packed RBCs per year in the last 2 years.
    - i. Dates of occurrence: \_\_\_\_\_
3. Please provide the member's weight: \_\_\_\_\_
4. Is the prescriber a hematologist or transplant specialist with expertise in the treatment of beta thalassemia and the administration of Zynteglo®? Yes \_\_\_ No \_\_\_
5. Does the member have a known and available human leukocyte antigen (HLA) fully-matched sibling donor? Yes \_\_\_ No \_\_\_
6. Does the member have a prior history of hematopoietic stem cell transplantation (HSCT)? Yes \_\_\_ No \_\_\_
7. Has the member previously received treatment with Casgevy™ (exagamglogene autotemcel)? Yes \_\_\_ No \_\_\_
8. Does the member have a negative serology test for human immunodeficiency virus (HIV) prior to apheresis? Yes \_\_\_ No \_\_\_
9. Has the prescriber verified the member is clinically stable and eligible to undergo HSCT? Yes \_\_\_ No \_\_\_
10. If member is female:
  - A. Is member pregnant? Yes \_\_\_ No \_\_\_
  - B. Will member have a negative pregnancy test prior to the start of mobilization, prior to conditioning procedures, and prior to Zynteglo® administration? Yes \_\_\_ No \_\_\_

**(Page 1 of 2)**

**PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:**

University of Oklahoma College of Pharmacy  
Pharmacy Management Consultants  
Product Based Prior Authorization Unit  
Fax: 1-800-224-4014  
Phone: 1-800-522-0114 Option 4

**CONFIDENTIALITY NOTICE**

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**Member Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_ **Member ID#:** \_\_\_\_\_

**Criteria**

**\*Page 2 of 2—Please complete and return all pages. Failure to complete all pages will result in processing delays.\*  
For Authorization, continued:**

11. If member is of reproductive potential, will they use an effective method of contraception from the start of mobilization through at least 6 months after administration of Zynteglo®? Yes\_\_\_ No\_\_\_
12. If member is of reproductive potential, has the prescriber counseled them on the potential effects of myeloablative conditioning on fertility, and the potential risk of infertility is acceptable to the member?  
Yes\_\_\_ No\_\_\_
13. Will the prescriber evaluate the potential for drug interactions, according to package labeling, prior to and after administration of Zynteglo®? Yes\_\_\_ No\_\_\_
14. Will member be monitored for hematologic malignancies lifelong, with a complete blood count (with differential) performed at month 6 and month 12 after treatment with Zynteglo®, then at least annually thereafter for at least 15 years, and with integration site analysis at months 6,12, and as warranted? Yes\_\_\_ No\_\_\_
15. Will Zynteglo® be administered at a Zynteglo® qualified treatment center? Yes\_\_\_ No\_\_\_  
A. Please provide name of treatment center: \_\_\_\_\_
16. Does the receiving facility have a mechanism in place to track the patient-specific Zynteglo® dose from receipt to storage to administration? Yes\_\_\_ No\_\_\_  
A. Please provide name of facility: \_\_\_\_\_

**Additional information:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

*(Page 2 of 2)*

**Prescriber Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

*I certify that the indicated treatment is medically necessary and all information is true and correct to the best of my knowledge. Failure to complete this form in full and attach requested clinical notes will result in processing delays.*

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