

Casgevy™ (Exagamglogene 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 Casgevy™ infusion will be approved per member per lifetime):

1. Please indicate the requested information:

- a. Is Casgevy™ being prescribed by a hematologist with expertise in the treatment of SCD or TDT and the administration of Casgevy™? Yes ___ No ___
- b. Does the member have a known and available human leukocyte antigen (HLA)-matched sibling donor? Yes ___ No ___
- c. Does the member have a prior history of hematopoietic stem cell transplantation (HSCT)? Yes ___ No ___
- d. Does the member have a negative serology test for human immunodeficiency virus (HIV) prior to apheresis according to package labeling? Yes ___ No ___
- e. Is the member clinically stable and eligible to undergo HSCT? Yes ___ No ___
- f. If member is female:
 - i. Is member pregnant? Yes ___ No ___
 - ii. Will member have a negative pregnancy test prior to the start of mobilization, prior to conditioning procedures, and prior to Casgevy™ administration? Yes ___ No ___
- g. 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 Casgevy™? Yes ___ No ___
- h. 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 ___
- i. Will the prescriber evaluate the potential for drug interactions, according to package labeling, prior to and after administration of Casgevy™? Yes ___ No ___
- j. Will Casgevy™ be administered at a Casgevy™ qualified treatment center? Yes ___ No ___
 - i. Please provide name of treatment center: _____
- k. Does the receiving facility have a mechanism in place to track the patient-specific Casgevy™ dose from receipt to storage to administration? Yes ___ No ___
 - i. Please provide name of facility: _____

*continued on next page
(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

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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:**

2. Please indicate the diagnosis and information:

Sickle Cell Disease (SCD)

- a. Does SCD include recurrent vaso-occlusive crises (VOCs)? Yes ___ No ___
- b. Does the member have evidence of severe disease as demonstrated by ≥ 2 severe vaso-occlusive events (VOEs) per year in the last 2 years? Yes ___ No ___
 - i. Dates of occurrence: _____
- c. Does the member have a trial of at least 1 pharmacological treatment option for SCD (i.e., hydroxyurea, L-glutamine, crizanlizumab-tmca)? Yes ___ No ___
 - i. If no, please provide a patient-specific, clinically significant reason why these options are not appropriate for the member: _____
- d. Has the member previously received treatment with Lyfgenia®? Yes ___ No ___
- e. Has the member discontinued disease modifying therapies 8 weeks prior to mobilization and conditioning? Yes ___ No ___
- f. Does prescriber verify that granulocyte-colony stimulating factor (G-CSF) will not be used for the CD34+ HSC mobilization? Yes ___ No ___

Transfusion-Dependent Beta Thalassemia (TDT)

- a. Does the member require regular red blood cell (RBC) transfusions as demonstrated by one of the following?
 - History of ≥ 100 mL/kg/year transfusions of packed RBCs in the last 2 years.
 - i. Dates of occurrence: _____
 - 10 units of packed RBCs per year in the last 2 years.
 - i. Dates of occurrence: _____
- b. Has the member previously received treatment with Zynteglo®? Yes ___ No ___

If diagnosis is not listed above, please indicate diagnosis: _____

Additional information: _____

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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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