HUSKY Health Program CASGEVY® (exagamglogene autotemcel)
Prior Authorization Request Form
Phone: 1.800.440.5071

THIS FORM IS TO BE COMPLETED BY THE ORDERING PROVIDER AND FAXED WITH CLINICAL DOCUMENTATION TO 203.265.3994.

Member Information				
Member ID #:		Member Name (Last, First):		
Address:		City, State, Zip:		
DOB:	Sex:	Weight:	Dose:	
Primary Diagnosis Code:		HCPCS Code:	Date of Service:	

Please indicate which disease this treatment is being requested for:

☐ **Sickle Cell Disease** ☐ **β-thalassemia**

Please fill out completely for ALL prior authorization requests.		
1. Is the individual 12 years of age or older?	○ Yes	○ No
2. Is this treatment being prescribed by or in consultation with a hematologist? ***If yes, please specify***: Hematologist Name: _____ Telephone Number: _____	○ Yes	○ No
3. Will the treatment be administered at an Authorized Treatment Center (ATC)? ***If yes, please specify:*** ATC Name/Location: _____	○ Yes	○ No
4. Is the individual eligible for a Hematopoietic stem-cell transplant (HSCT) as determined by the hematologist? ***Please attach provider attestation.***	○ Yes	○ No
5. Does the individual have an available 10/10 human leukocyte antigen-matched related donor? ***Please attach provider attestation.***	○ Yes	○ No
6. Has the individual previously received an HSCT? ***Please attach provider attestation.***	○ Yes	○ No
7. Has the individual previously received Casgevy or any other gene therapy? ***Please attach provider attestation.***	○ Yes	○ No
8. Does this individual have advanced liver disease? ***Please attach lab data/clinical documentation.***	○ Yes	○ No
9. Does the individual have a bacterial, viral, fungal, or parasitic infection including HIV-1, HIV-2, hepatitis B, or hepatitis C? ***Please attach lab data/clinical documentation.***	○ Yes	○ No
10. Does the individual have any prior or current malignancy, myeloproliferative disorder, or a significant immunodeficiency disorder? ***Please attach provider attestation.***	○ Yes	○ No
11. Will the treating provider follow all FDA recommendations for usage, dosage, preparation, administration, monitoring, and patient education?	○ Yes	○ No
Please fill out completely for prior authorization requests for individuals with *sickle cell disease* ONLY.		
1. Does the individual have a diagnosis of sickle cell disease with one of the following genotypes as confirmed by genetic testing: βS/βS, βS/β0, or βS/β+? ***Please attach genetic testing results.***	○ Yes	○ No
2. Does the individual have a history of ≥ two severe vaso-occlusive episodes per year in the two years prior to screening in the setting of appropriate supportive care? ***Please attach medical record documentation.***	○ Yes	○ No
3. Does the individual have a history or presence of Moyamoya disease? ***Please attach provider attestation.***	○ Yes	○ No
4. Has the individual previously trialed at least one pharmacologic treatment for SCD including hydroxyurea, l-glutamine, crizanlizumab-tmca, or voxelotor? ***Please attach medical record documentation.***	○ Yes	○ No
5. In individuals 12-18 years of age ONLY: a. Does the individual have a history of abnormal transcranial doppler (TCD) (TAMMV ≥200 cm/sec for non-imaging TCD and ≥185 cm/sec for imaging TCD)? ***Please attach medical record documentation.***	○ Yes	○ No
Please fill out completely for prior authorization requests for individuals with *β-thalassemia* ONLY.		
1. Does the individual have a diagnosis of β-thalassemia as confirmed by genetic testing? ***Please attach genetic testing results.***	○ Yes	○ No
2. Does the individual have a history of ≥100 mL/kg/year or ≥10 units/year of RBC transfusions in the previous two years? ***Please attach medical record documentation.***	○ Yes	○ No

Billing Provider Information	
Medicaid Billing Number:	Billing Provider Name:
Street Address:	City, State, Zip:
Contact Name:	Contact Telephone Number:
Contact Fax Number:	

Ordering Provider Information	
Medicaid Billing Number:	Ordering Provider Name:
Street Address:	City, State, Zip:
Contact Name:	Contact Telephone Number:
Contact Fax Number:	Provider Specialty:

Certification Statement: This is to certify that the requested treatment is medically indicated and is reasonable and necessary for the treatment of this patient and that a prescribing practitioner-signed order is on file. This form and any statement on my letterhead attached hereto has been completed by me or by my employee and reviewed by me. The foregoing information is true, accurate, and complete, and I understand that any falsification, omission, or concealment of material fact may subject me to civil and criminal liability.

Provider Signature:	Date: