HUSKY Health Program CASGEVY® (exagamglogene autotemcel)
Sickle Cell Disease
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 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) and prescribed in consultation with a board-certified hematologist with sickle cell disease expertise? ***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 stating that the individual does not have any of the following:*** • Advanced liver disease • A bacterial, viral, fungal, or parasitic infection including active HIV-1, HIV-2, hepatitis B, or hepatitis C • Any prior or current malignancy, myeloproliferative disorder, or a significant immunodeficiency disorder • A history or presence of Moyamoya disease • *For individuals 12-18 years of age ONLY*: a history of abnormal transcranial doppler (TCD) (TAMMV ≥200 cm/sec for non-imaging TCD and ≥185 cm/sec for imaging TCD)	○Yes	○No
5. Has the individual previously received an allogenic or autologous hematopoietic stem cell transplant or other gene therapy? ***Please attach provider attestation.***	○Yes	○No
6. Will the treating provider follow all FDA recommendations for usage, dosage, preparation, administration, and monitoring?	○Yes	○No
7. Does the individual have confirmatory genetic testing for sickle cell disease? ***Please attach genetic testing results.***	○Yes	○No
8. Does the individual have a history of ≥ two vaso-occlusive (VOC) episodes per year in the two years prior to screening or currently receiving chronic transfusion therapy for recurrent VOCs? ***Please attach provider attestation.***	○Yes	○No
9. Has the individual had prior use of or intolerance to (per health care professional judgement), at least one pharmacologic treatment for SCD including hydroxyurea, l-glutamine, crizanlizumab-tmca, or voxelotor at any point in the past? ***Please attach provider attestation.***	○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: