HUSKY Health Program Lenmeldy® (atidarsagene 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:	Primary Diagnosis Code:	
Date of Service:		HCPCS Code:	

Please fill out completely for all requests:		
1. Does the individual have a diagnosis of Metachromatic Leukodystrophy (MLD)? ***Please attach medical record documentation.***	◯Yes	◯No
2. Does the individual have Arylsulfatase A (ARSA) activity below the normal range? ***Please attach clinical test results.***	◯Yes	◯No
3. Does the individual have two disease-causing ARSA mutations of either known or novel alleles? ***Please attach genetic testing.***	◯Yes	◯No
4. Does the individual have presence of sulfatides in a 24-hour urine collection? ***Please attach clinical test results.***	◯Yes	◯No
5. Does the individual have one of the following subtypes of MLD? ***Please specify below and attach medical record documentation.*** ☐ Pre-symptomatic Late Infantile (PSLI) ☐ Pre-symptomatic Early Juvenile (PSEJ) ☐ Early Symptomatic Early Juvenile (ESEJ)	◯Yes	◯No
6. Is Lenmeldy® prescribed by, or in consultation with, a hematologist or a physician who specializes in the treatment of MLD? ***If yes, please specify:*** Provider Name: _____ Phone Number: _____	◯Yes	◯No
7. Does the individual have evidence of any of the following infections? ***Please attach signed provider attestation.***	◯Yes	◯No
a. Hepatitis B Virus (HBV)	◯Yes	◯No
b. Hepatitis C Virus (HCV)	◯Yes	◯No
c. Human T-Cell Lymphotropic Virus 1 & 2 (HTLV-1/HTLV-2)	◯Yes	◯No
d. Human Immunodeficiency Virus 1 & 2 (HIV-1/HIV-2)	◯Yes	◯No
e. Cytomegalovirus (CMV)	◯Yes	◯No
f. Mycoplasma infection	◯Yes	◯No
8. Has the individual been evaluated for risk factors for thrombosis and thromboembolic events?	◯Yes	◯No
a. Is prophylaxis indicated for this individual?	◯Yes	◯No
i. If yes, will the individual be provided with prophylaxis?	◯Yes	◯No
b. Will the individual continue to be monitored for thrombosis and thromboembolic events after infusion? ***Please attach signed provider attestation.***	◯Yes	◯No
9. Has the individual been evaluated for risk factors for veno-occlusive disease?	◯Yes	◯No
a. Is prophylaxis indicated for this individual?	◯Yes	◯No
i. If yes, will the individual be provided with prophylaxis?	◯Yes	◯No
b. Will the individual continue to be monitored for veno-occlusive disease after infusion? ***Please attach signed provider attestation.***	◯Yes	◯No
10. Does the provider attest that the individual will NOT receive any vaccinations during the six weeks preceding the start of myeloablative conditioning, and until hematological recovery following treatment as outlined in the FDA-approved labeling for Lenmeldy®? ***Please attach signed provider attestation.***	◯Yes	◯No
11. Is the individual considered to be an eligible candidate for Hematopoietic Stem Cell (HSC) gene therapy? ***Please attach signed provider attestation.***	◯Yes	◯No
12. Has the individual previously received an allogenic HSC transplant?	◯Yes	◯No
If yes:		
a. Is there evidence of residual cells of donor origin?	◯Yes	◯No
b. Have at least six months passed since the allogenic HSC transplant? ***Please attach signed provider attestation.***	◯Yes	◯No
13. Has the individual previously received Lenmeldy® or any other gene therapy? ***Please attach signed provider attestation.***	◯Yes	◯No
14. Will the treating provider follow all FDA-approved labeling for usage, dosage, preparation, administration, monitoring, and patient education for Lenmeldy®?	◯Yes	◯No

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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 medication 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: