

**Lyfgenia<sup>®</sup> (Lovotibeglogene 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 Lyfgenia<sup>®</sup> infusion will be approved per member per lifetime):**1. Please indicate the diagnosis and information:** **Sickle Cell Disease (SCD)**

- a. Is SCD confirmed by genetic testing? Yes\_\_\_ No\_\_\_
- b. Has member failed, or is intolerant to hydroxyurea (defined as being unable to take hydroxyurea per health care professional judgement) at any point in the past? Yes\_\_\_ No\_\_\_
- c. Expected date of gene therapy administration: \_\_\_\_\_
- d. Is member clinically stable and fit for transplantation? Yes\_\_\_ No\_\_\_
- e. Is Lyfgenia<sup>®</sup> prescribed by or in consultation with a board-certified hematologist with SCD expertise? Yes\_\_\_ No\_\_\_
- f. Does member's treatment center have a Sickle Cell Center? Yes\_\_\_ No\_\_\_
- g. Select one:
  - Member is currently receiving chronic transfusion therapy for recurrent Vaso-Occlusive Events (VOEs)
  - Member experienced  $\geq 4$  VOEs in previous 24 months as determined by the treating clinician
- h. Has member previously received treatment with Casgevy<sup>®</sup>? Yes\_\_\_ No\_\_\_

 **Other:** \_\_\_\_\_

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

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.***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***This document, including any attachments, contains information which is confidential or privileged. If you are not the intended recipient, be aware that any disclosure, copying, distribution, or use of the contents of this information is prohibited. If you have received this document in error, please notify the sender immediately by telephone to arrange for the return of the transmitted documents or to verify their destruction.*