

**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:****1. Please indicate the diagnosis and information:**

- Sickle Cell Disease (SCD)** (*Approvals will be for a duration of 12 months*)
- Is diagnosis confirmed by genetic testing? Yes \_\_\_ No \_\_\_
  - Does member have evidence of disease as demonstrated by  $\geq 2$  vaso-occlusive crises (VOCs) per year in the last 2 years? Yes \_\_\_ No \_\_\_
  - Is Casgevy® prescribed by, or in consultation with, a board-certified hematologist with expertise in the treatment of SCD and the administration of Casgevy®? Yes \_\_\_ No \_\_\_
  - Does member have a documented trial with hydroxyurea? Yes \_\_\_ No \_\_\_
  - Is the member clinically stable and eligible to undergo hematopoietic stem cell transplantation (HSCT)? Yes \_\_\_ No \_\_\_ (*HSCT must be appropriate for a member to be treated with Casgevy®*)
- Transfusion-Dependent Beta Thalassemia (TDT)** (*Only one infusion will be approved per member per lifetime*)
- Is Casgevy® being prescribed by a hematologist with expertise in the treatment of TDT and the administration of Casgevy®? Yes \_\_\_ No \_\_\_
  - Does the member have a known and available human leukocyte antigen (HLA)-matched sibling donor? Yes \_\_\_ No \_\_\_
  - Does the member have a prior history of hematopoietic stem cell transplantation (HSCT)? Yes \_\_\_ No \_\_\_
  - Does the member have a negative serology test for human immunodeficiency virus (HIV) prior to apheresis according to package labeling? Yes \_\_\_ No \_\_\_
  - Is the member clinically stable and eligible to undergo HSCT? Yes \_\_\_ No \_\_\_
  - If member is female:
    - Is member pregnant? Yes \_\_\_ No \_\_\_
    - Will member have a negative pregnancy test prior to the start of mobilization, prior to conditioning procedures, and prior to Casgevy® administration? Yes \_\_\_ No \_\_\_

*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

**CONFIDENTIALITY NOTICE**

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**Casgevy® (exagamglogene autotemcel) Prior Authorization Form****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.\*****2. Please indicate the diagnosis and information:** **Transfusion-Dependent Beta Thalassemia (TDT)** *(continued)*

- 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: \_\_\_\_\_
- l. Does the member require regular red blood cell (RBC) transfusions as demonstrated by one of the following?  
 History of  $\geq 100\text{mL/kg/year}$  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: \_\_\_\_\_
- m. Has the member previously received treatment with Zynteglo®? Yes \_\_\_ No \_\_\_

 **If diagnosis is not listed above, please indicate diagnosis:** \_\_\_\_\_**Additional information:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_*(Page 2 of 2)***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  
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