CASGEVY (exagamglogene autotemcel) PRIOR AUTHORIZATION FORM

(form effective 7/15/2024)

Keystone First | PERFORMRx℠ Next Generation Pharmacy Benefits

Fax to PerformRx℠ at **1-866-497-1387**, or to speak to a representative call **1-800-588-6767**.

BENEFICIARY INFORMATION

Beneficiary name:	Beneficiary ID#:	DOB:

PRESCRIBER INFORMATION

Prescriber name:	
Specialty:	NPI:
Prescriber address (street/city/state/zip):	
Prescriber phone:	Prescriber fax:

OFFICE CONTACT INFORMATION

Office contact name:	
Office contact phone:	Office contact fax:

BILLING PROVIDER INFORMATION

Billing provider name:	Billing provider NPI:
Billing provider address:	

CLINICAL INFORMATION

Drug name: Casgevy	Beneficiary's weight (kg):	Dose:_____ x 10^6 CD34+ cells/kg
Place of service:		Anticipated date of infusion:
Diagnosis *(submit documentation)*:		Dx code *(required)*:

INITIAL REQUESTS

Complete all sections that apply to the beneficiary and this request.
Check all that apply and *submit documentation* (e.g., recent chart/clinic notes, diagnostic evaluations, test results) for each item.

1. For ALL DIAGNOSES:

☐ Has NOT received prior gene therapy.

☐ Has NOT received a prior allogeneic hematopoietic stem cell transplant.

2. For the treatment of SICKLE CELL DISEASE:

☐ Has sickle cell disease with a ßS/ßS, ßS/ß0, or ßS/ß+ genotype.

☐ At least one of the following:

- ☐ Has a history of vaso-occlusive episodes (e.g., pain crises, acute chest syndrome, splenic sequestration, priapism) that required a medical facility visit (e.g., emergency department, hospital).
- ☐ Is currently receiving chronic transfusion therapy for recurrent vaso-occlusive episodes.

3. For the treatment of TRANSFUSION-DEPENDENT ß-THALASSEMIA:

☐ Has genetic testing confirming the diagnosis of ß-thalassemia.

☐ Has a history of at least 100 mL/kg/year or 8 transfusion episodes/year of packed red blood cell transfusions in the prior 2 years.

PLEASE FAX COMPLETED FORM WITH SUPPORTING CLINICAL DOCUMENTATION

Prescriber signature:	Date: