UTAH MEDICAID PHARMACY PRIOR AUTHORIZATION REQUEST FORM

Casgevy (exagamglogene autotemcel) for Sickle Cell Disease

Member and Medication Information * indicates required field	
*Member ID:	*Member Name:
*DOB:	*Weight:
*Medication Name/ Strength:	
☐ Do Not Substitute. Authorizations will be processed for the preferred Generic/Brand equivalent unless specified.	
*Directions for use:	
Provider Information * indicates required field	
*Requesting Provider Name:	*Requesting Prescriber NPI:
Address:	
*Contact Person:	*Office Phone:
*Office Fax:	*Office Email:
Medically Billed Information * indicates required field for all medically billed products	
*Diagnosis Code:	*HCPCS Code:
*Dosing Frequency:	*HCPCS Units per Dose:
Servicing Provider Name:	NPI:
Servicing Provider Address:	
Facility/Clinic Name:	NPI:
Facility/Clinic Address:	
Fax form and relevant documentation including: laboratory results, chart notes and/or updated provider letter to Pharmacy PA at **855-828-4992**, to prevent processing delays.	

Criteria for Approval: (*All* of the following criteria must be met)

1. Is the patient at least 12 years of age or older? ❑ **Yes** ❑ **No**
2. Does the patient have a diagnosis of Sickle cell disease confirmed with genetic testing with one of the following genotypes βS/βS or βS/β0 or βS/β+, with recurrent vaso-occlusive crises (VOCs) defined as history of ≥2 VOCs annually within the past 2 years? ❑ **Yes** ❑ **No**
3. Does the patient not have active Human Immunodeficiency Virus, Hepatitis B Virus, or Hepatitis C Virus? ❑ **Yes** ❑ **No**
4. Has the patient received prior allo or auto hematopoietic stem cell (HSC) transplant? ❑ **Yes** ❑ **No**
5. Has the patient tried and failed or has an intolerance to, or a contraindication to hydroxyurea or one other disease-modifying pharmacologic agent (eg, L-glutamine, voxelotor)? ❑ **Yes** ❑ **No**
   Medication: _____ Details: _____

Initial Authorization: One-time single dose only

Note:

- Provider shall review and submit additional Ultra High Cost Drug Forms below at: https://medicaid.utah.gov/pharmacy/resource-library/
  - UHCD Written Claim of Business Confidentiality Form

- ➢ Ultra High Cost Drug Invoice Submission Form

- ❖ If the patient is eligible to enroll in the Cell and Gene Therapy Model, the provider/hospital **MUST NOT** claim 340b discounts on this Casgevy invoice

PROVIDER CERTIFICATION

I hereby certify this treatment is indicated, necessary and meets the guidelines for use.

_____ _____

Prescriber's Signature Date