



Prior Authorization Request Form for Casgevy (exagamglogene autotemcel)

FAX this completed form to (844) 205-3386

OR Mail requests to: Pharmacy Department | 5 River Park Place East, Suite 210 | Fresno, CA 93720

OR Prior authorization may be completed at <https://www.covermymeds.com/main/prior-authorization-forms/>

Member name:	Member ID#:	Member DOB:
Prescriber name:	Prescriber NPI:	
Prescriber address (street/city/state/zip):		
Prescriber specialty:	Prescriber phone:	Prescriber fax:
Office contact name:	Office contact phone:	Office contact fax:
Billing provider name:	Billing provider NPI:	
Billing provider address:		

Drug name: Casgevy	Member's weight (kg):	Dose: _____ x 10 ⁶ CD34+ cells/kg
Place of service:	Anticipated date of infusion:	
Diagnosis (<i>submit documentation</i>):	DX code (<i>required</i>):	

Complete the sections below that apply to the Member and this request.

Check all that apply and submit documentation (e.g., recent chart notes, diagnostic evaluations, test results, etc.) for each item.

- For ALL DIAGNOSES:**
 - Has NOT received prior gene therapy.
 - Has NOT received a prior allogeneic hematopoietic stem cell transplant.
- For the treatment of SICKLE CELL DISEASE:**
 - Has sickle cell disease with a β S/ β S, β S/ β 0, or β S/ β + 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.
- For the treatment of TRANSFUSION-DEPENDENT β -THALASSEMIA:**
 - Has genetic testing confirming the diagnosis of β -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 TO (844) 205-3386.

Prescriber Signature:	Date:
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