



Prior Authorization Request Form for Lyfgenia (lovotibeglogene 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: Lyfgenia	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>):	

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

- Has NOT received prior gene therapy.
- Has NOT received a prior allogeneic hematopoietic stem cell transplant.
- Has sickle cell disease with a $\beta S/\beta S$, $\beta S/\beta 0$, or $\beta S/\beta +$ 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.

PLEASE FAX COMPLETED FORM WITH SUPPORTING CLINICAL DOCUMENTATION TO (844) 205-3386.

Prescriber Signature:	Date:
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