



New Hampshire Medicaid Fee-for-Service (FFS) Program

Prior Authorization Drug Approval Form

Encelto™ (revakinagene taroretcel-lwey)

DATE OF MEDICATION REQUEST: / /

SECTION I: PATIENT INFORMATION AND MEDICATION REQUESTED

LAST NAME:

Grid for last name input

FIRST NAME:

Grid for first name input

MEDICAID ID NUMBER:

Grid for Medicaid ID number input

DATE OF BIRTH:

Grid for date of birth input

GENDER: Male Female

Drug Name

Strength

Dosing Directions

Length of Therapy

SECTION II: PRESCRIBER INFORMATION

LAST NAME:

Grid for last name input

FIRST NAME:

Grid for first name input

SPECIALTY:

NPI NUMBER:

Grid for NPI number input

PHONE NUMBER:

Grid for phone number input

FAX NUMBER:

Grid for fax number input

SECTION III: CLINICAL HISTORY

1. Is the patient 18 years of age and older? Yes No

2. Does the patient have a diagnosis of macular telangiectasia type 2 (MacTel) in at least one eye as evidenced by typical fluorescein leakage and at least 1 of the following? If yes, identify the additional features. (Select all that apply.)

- Hyperpigmentation outside a 500 micron radius from the center of the fovea
Retinal opacification
Crystalline deposits
Right-angle vessels
Inner/outer lamellar cavities

Fax to Prime Therapeutics Management LLC if medications will be dispensed by a pharmacy and will be administered by the patient or caregiver at home.

Phone: 1-866-675-7755

Fax: 1-888-603-7696

Fax to DHHS if medication is dispensed/administered by the office or outpatient setting:

Phone: 1-603-271-9384

Fax: 1-603-314-8101



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**PATIENT LAST NAME:**

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**PATIENT FIRST NAME:**

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3. Does the patient have neovascular MacTel?  Yes  No
4. Does the patient have evidence of advanced disease, such as significant retinal scarring or atrophy with retinal tissue that cannot be preserved?  Yes  No
5. Does the patient have inner segment-outer segment junction line (IS/OS) photoreceptor break and area of ellipsoid zone (EZ) loss, as measured by spectral-domain optical coherence tomography (SD-OCT)?  Yes  No
6. Does the patient have evidence of any of the following: (select all that apply)  Yes  No
  - Intraretinal neovascularization or subretinal revascularization (SRNV) as evidenced by hemorrhage, hard exudate, subretinal fluid, or intraretinal fluid in either eye
  - Central serous chorioretinopathy in either eye
  - Pathologic myopia in either eye
  - Significant media or corneal opacities in either eye
  - History of vitrectomy, penetrating keratoplasty, trabeculectomy, or trabeculoplasty
  - Lens opacities: cortical opacity > 3 standard, posterior subcapsular opacity > standard 2, or nuclear opacity > standard 3
  - Lens removal in previous 3 months or yttrium-aluminum-garnet laser treatment within 4 weeks
  - History of ocular herpes virus in either eye
  - Evidence of intraretinal hyperreflectivity by optical coherence tomography (OCT)
7. Does the patient have ocular or periocular infections?  Yes  No
8. Does the patient have a known hypersensitivity to Endothelial Serum Free Media (Endo-SFM)?  Yes  No
9. Prescriber attests that the patient will be monitored for signs and symptoms of vision loss and infectious endophthalmitis at baseline and periodically during treatment.  Yes  No
10. Prescriber attests that the patient will be monitored for signs and symptoms of retinal tears and retinal detachment.  Yes  No
11. Does the patient have evidence of other ocular disease that would preclude treatment of MacTel?  Yes  No
12. Will the patient temporarily discontinue antithrombotic medications (if applicable) prior to the insertion surgery? Leave blank if not applicable.  Yes  No

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**PATIENT FIRST NAME:**

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13. Has the patient received intravitreal steroid therapy or intravitreal anti-vascular endothelial growth factor (VEGF) therapy for non-neovascular MacTel within the last 3 months?  Yes  No
14. Is there any additional information that would help in the decision-making process?  
 If additional space is needed, please use a separate sheet.

**I certify that the information provided is accurate and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.**

**PRESCRIBER'S SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

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