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**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:**

**FIRST NAME:**

**MEDICAID ID NUMBER:**

**DATE OF BIRTH:** – –

**GENDER:** ☐ Male ☐ Female

**Drug Name**

**Strength**

**Dosing Directions**

**Length of Therapy**

## SECTION II: PRESCRIBER INFORMATION

**LAST NAME:**

**FIRST NAME:**

**SPECIALTY:**

**NPI NUMBER:**

**PHONE NUMBER:** – –

**FAX NUMBER:** – –

## 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.)** ☐ Yes ☐ No
   - ☐ 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


Revision Date: 11/01/2025

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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), between 0.16 $mm^2$ and $2mm^2$? ☐ 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 yytrium-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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