



# New Hampshire Medicaid Fee-for-Service Program Prior Authorization Drug Approval Form

Lenmeldy™ (atidarsagene autotemcel)

DATE OF MEDICATION REQUEST:     /     /

## SECTION I: PATIENT INFORMATION AND MEDICATION REQUESTED

LAST NAME:

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FIRST NAME:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

MEDICAID ID NUMBER:

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DATE OF BIRTH:

				-					-						
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GENDER:    Male    Female

Drug Name:

Strength:

Dosing Directions:

Length of Therapy:

## SECTION II: PRESCRIBER INFORMATION

LAST NAME:

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FIRST NAME:

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SPECIALTY:

NPI NUMBER:

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PHONE NUMBER:

				-					-						
--	--	--	--	---	--	--	--	--	---	--	--	--	--	--	--

FAX NUMBER:

				-					-						
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## SECTION III: CLINICAL HISTORY

- Is the patient under 18 years of age?  Yes    No
- Does the patient have a documented diagnosis of metachromatic leukodystrophy (MLD) that has been confirmed by one of the following? (Check all that apply.)
  - Arylsulfatase A (ARSA) enzyme activity below normal range in peripheral mononuclear cells
  - Increased urinary excretion of sulfatides and presence of biallelic ARSA pathogenic mutation of known polymorphisms
- Does the patient have pre-symptomatic late infantile (PSLI), presymptomatic early juvenile (PSEJ), or early symptomatic early juvenile (ESEJ) disease?  Yes    No

(Form continued on next page.)

Fax to DHHS; medication is administered in inpatient setting:

Phone: 1-603-271-9384

Fax: 1-603-314-8101

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Review Date: 07/01/2024







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**FIRST NAME:**

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

**SECTION III: CLINICAL HISTORY (Continued)**

Provide 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:** \_\_\_\_\_

Facility where infusion to be provided: \_\_\_\_\_

Medicaid Provider Number of Facility: \_\_\_\_\_

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