Reset Form Print Form

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

Skysona™ (elivaldogene autotemcel)

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 a male at least four years of age but less than 18 years of age? ☐ Yes ☐ No
2. Is the diagnosis early, active cerebral adrenoleukodystrophy (CALD)? ☐ Yes ☐ No
3. Provide very-long-chain fatty acids (VLCFA) values and documentation:
   - C26:0, 1.30 + 0.45 (normal: 0.23 + 0.09): _____
   - C24:0/C22:0, 1.71 + 0.23 (normal: 0.84 + 0.10): _____
   - C26:0/C22:0, 0.07 + 0.03 (normal: 0.01 + 0.004): _____
4. Provide genetic testing results showing *ABCD1* mutation.

(Form continued on next page.)

Fax to DHHS; medication is administered in inpatient setting:

Phone: 1-866-675-7755 **Fax**: 1-888-603-7696

Review Date: 06/10/2024

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PATIENT FIRST NAME:

SECTION III: CLINICAL HISTORY *(Continued)*

5. Does the patient have active central nervous system (CNS) disease established by a central radiographic review of brain magnetic resonance imaging (MRI)? ☐ Yes ☐ No
   - Provide Loes score: _____ (34-point scale)
   - Does the MRI show demyelinating lesions with gadolinium enhancement? ☐ Yes ☐ No
6. What is the patient's neurological function score (NFS)? _____
7. Has the patient has been screened for the following conditions? ☐ Yes ☐ No
   - hepatitis B virus (HBV)
   - hepatitis C virus (HCV)
   - human T-lymphotrophic virus 1 and 2 (HTLV-1/HTLV-2)
   - human immunodeficiency virus 1 and 2 (HIV-1/HIV-2)
8. Does the patient have an active infection, including clinically important localized infections? ☐ Yes ☐ No
9. Will prophylaxis for infection be followed according to standard institutional guidelines? ☐ Yes ☐ No
10. Is the patient up to date with all age-appropriate vaccinations, in accordance with current vaccination guidelines? ☐ Yes ☐ No
11. Do you attest that the patient will receive periodic, life-long monitoring for hematological malignancies? ☐ Yes ☐ No
12. Will anti-retroviral medications be avoided one month prior to and throughout all cycles of apheresis? ☐ Yes ☐ No
13. Does the patient have head trauma induced disease? ☐ Yes ☐ No
14. Will Skysona be used to prevent the development of or treat adrenal insufficiency? ☐ Yes ☐ No
15. Has the patient had a hematopoietic stem cell transplant? ☐ Yes ☐ No
16. Does the patient have a known or available human leukocyte antigen (HLA)-matched willing family donor? ☐ Yes ☐ No

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SECTION III: CLINICAL HISTORY *(Continued)*

Please 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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