Reset Form Print Form

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

Waskyra (etuvetidigene 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 at least 6 months of age? ☐ Yes ☐ No
2. Does the patient have a confirmed diagnosis of Wiskott-Aldrich Syndrome (WAS) with severe phenotype WAS mutation? ☐ Yes ☐ No
   - Genetic testing has been completed
3. Does the patient have a medically-eligible 10/10 human leukocyte antigen (HLA)-identical matched stem cell donor? ☐ Yes ☐ No
4. Has the patient received a prior allogeneic hematopoietic stem cell transplant (HSCT) in the past 6 months? ☐ Yes ☐ No
5. Will Waskyra be used as a single agent for treatment of WAS? ☐ Yes ☐ No
6. Has the patient received prior hematopoietic stem cell-based gene therapy? ☐ Yes ☐ No
7. Does the patient have a history of hypersensitivity to dimethyl sulfoxide (DMSO)? ☐ 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

Review Date: 06/01/2026

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SECTION III: CLINICAL HISTORY *(Continued)*

8. Has the patient had a negative HIV test prior to mobilization? ☐ Yes ☐ No
9. Will the patient be monitored for signs and symptoms of veno-occlusive disease through the first month following infusion? ☐ Yes ☐ No
   - Include liver function tests
10. Will the patient be monitored for signs and symptoms of serious infection and receive prophylactic antimicrobials according to institutional guidelines? ☐ Yes ☐ No
11. Has the patient's immunoglobulin G serum level been assessed to be above 5g/L? ☐ Yes ☐ No
12. Will the patient be monitored for malignancy periodically after treatment? ☐ Yes ☐ No
13. Will granulocyte-colony stimulating factor (G-CSF) and plerixafor be used for stem cell mobilization? ☐ Yes ☐ No
14. Has the prescriber reviewed the warnings/precautions and drug interactions and will monitor the patient accordingly? ☐ Yes ☐ No
15. Females: Has pregnancy been ruled out prior to starting mobilization and will lack of pregnancy be re-confirmed prior to conditioning procedures and again before administration of Waskyra? ☐ Yes ☐ No
16. Males: If childbearing age, education will be provided for effective contraception from mobilization to 6 months following Waskyra administration? ☐ Yes ☐ No

(Form continued on next page.)

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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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