



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

Zynteglo® (betibeglogene autotemcel)

DATE OF MEDICATION REQUEST: / /

SECTION I: PATIENT INFORMATION AND MEDICATION REQUESTED

LAST NAME:

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FIRST NAME:

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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:

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FAX NUMBER:

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SECTION III: CLINICAL HISTORY

- Is the patient at least 4 years of age? Yes No
- Does the patient have a documented diagnosis of beta thalassemia that has been confirmed by the following? Yes No
 - Beta-globin gene (HBB) sequence gene analysis showing biallelic pathogenic variants
 - Peripheral blood smear and hemoglobin analysis revealing decreased amounts or complete absence of hemoglobin A and increased amounts of hemoglobin F
- Does the patient have transfusion-dependent disease as defined by the following criteria? Yes No
 - transfusions of at least 100 mL/kg/year of packed red blood cells (pRBCs)
 - 8 or more transfusions of pRBCs per year in the 2 years preceding therapy

(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: 06/10/2024





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LAST NAME:

Grid for last name input

FIRST NAME:

Grid for first name input

SECTION III: CLINICAL HISTORY (Continued)

- 4. Does the patient have any of the following conditions?
5. Has the patient has been screened for the following conditions?
6. Will anti-retroviral medications and hydroxyurea be avoided one month prior to and throughout all cycles of apheresis?
7. Will iron chelation therapy be discontinued for 7 or more days prior to initiating myeloablative conditioning therapy?
8. 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 Zynteglo®?
9. Will Zynteglo® be used as a single-agent therapy?
10. Do you attest that the patient will receive periodic, life-long monitoring for hematological malignancies?
11. Is the patient eligible to undergo hematopoietic stem cell transplant (HSCT)?
12. Has the patient had a hematopoietic stem cell transplant?

(Form continued on next page.)

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FIRST NAME:

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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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