OKLAHOMA Health Care Authority

State of Oklahoma
SoonerCare

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Zynteglo® (Betibeglogene Autotemcel) Prior Authorization Form

Member Name: _____ ***Date of Birth:*** _____ ***Member ID#:*** _____

Drug Information

Physician billing (HCPCS code: _____***)*** ***Start Date:*** _____

Billing Provider Information

Provider NPI: _____ ***Provider Name:*** _____

Provider Phone: _____ ***Provider Fax:*** _____

Prescriber Information

Prescriber NPI: _____ ***Prescriber Name:*** _____

Prescriber Phone: _____ ***Prescriber Fax:*** _____ ***Specialty:*** _____

Criteria

For Authorization: (Only <u>one</u> Zynteglo® infusion will be approved per member per lifetime):

1. Please indicate the member's diagnosis:
   - ☐ Beta Thalassemia
   - ☐ Other: _____
2. Does the member require regular red blood cell (RBC) transfusions as demonstrated by one of the following?
   - ☐ History of ≥100mL/kg/year transfusions of packed RBCs in the last 2 years.
   - ☐ ≥8 transfusions of packed RBCs per year in the last 2 years.
3. Please provide the member's weight: _____
4. Is the prescriber a hematologist with expertise in the treatment of beta thalassemia and the administration of Zynteglo®? Yes☐ No☐
5. Does the member have a known and available human leukocyte antigen (HLA)-matched sibling donor? Yes☐ No☐
6. Does the member have a prior history of hematopoietic stem cell transplantation (HSCT)? Yes☐ No☐
7. Does the member have a negative serology test for human immunodeficiency virus (HIV) prior to apheresis? Yes☐ No☐
8. Has the prescriber verified the member is clinically stable and eligible to undergo HSCT? Yes☐ No☐
9. If member is female:
   - A. Is member pregnant? Yes☐ No☐
   - B. Will member have a negative pregnancy test prior to the start of mobilization, prior to conditioning procedures, and prior to Zynteglo® administration? Yes☐ No☐
10. If member is of reproductive potential, will they use an effective method of contraception from the start of mobilization through at least 6 months after administration of Zynteglo®? Yes☐ No☐
11. If member is of reproductive potential, has the prescriber counseled them on the potential effects of myeloablative conditioning on fertility, and the potential risk of infertility is acceptable to the member? Yes☐ No☐
12. Will the prescriber evaluate the potential for drug interactions, according to package labeling, prior to and after administration of Zynteglo®? Yes☐ No☐
13. Will member be monitored for hematologic malignancies lifelong, with a complete blood count (with differential) performed at month 6 and month 12 after treatment with Zynteglo®, then at least annually thereafter for at least 15 years, and with integration site analysis at months 6,12, and as warranted? Yes☐ No☐

Fax completed prior authorization request form to **888-601-8461** or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts.
All requested data must be provided. Incomplete forms or forms without the chart notes will be returned. Pharmacy Coverage Guidelines are available at **AetnaBetterHealth.com/Oklahoma.**

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Page 2 of 2—Please complete and return <u>all</u> pages. Failure to complete all pages will result in processing delays.
For Authorization, continued:

14. Will Zynteglo® be administered at a Zynteglo® qualified treatment center? Yes☐ No☐
    A. Please provide name of treatment center: _____
15. Does the receiving facility have a mechanism in place to track the patient-specific Zynteglo® dose from receipt to storage to administration? Yes☐ No☐
    A. Please provide name of facility: _____

Additional information: _____

_____

_____

_____

_____

_____

Prescriber Signature: _____ **Date:** _____

I certify that the indicated treatment is medically necessary and all information is true and correct to the best of my knowledge.
Failure to complete this form in full and attach requested clinical notes will result in processing delays.

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