# Exagamglogene Autotemcel (Exa-Cel)

## Prior Authorization Form/Prescription

peach state health plan

**Telephone: (800) 514-0083 option 2**
**Fax: (866) 374-1579**

Date: _____ Date Medication Required: _____
Ship to: ❍ Physician ❍ Patient's Home ❍ Other _____

## Patient Information

| *Last Name: | *First Name: | Middle: | *DOB: ____/____/_____ |
|---|---|---|---|
| Daytime Phone: | Evening Phone: | *Sex: ☐ Male ☐ Female | |

## Insurance Information (*Attach copies of cards*)

| *Primary Insurance: | | Secondary Insurance: | |
|---|---|---|---|
| *ID #: | Group #: | ID #: | Group #: |

## Physician Information

| *Name: | *Specialty: | NPI: |
|---|---|---|
| *Phone #: | Secure Fax #: | Office Contact: |

## Procedural Hospital

*Hospital Name:

## Primary Diagnosis

*ICD-10 Code: _____

☐Transfusion-Dependent β-Thalassemia (TDT) ☐Sickle cell disease (SCD) ☐Other: _____

## Prescription Information

| MEDICATION | STRENGTH | *DIRECTIONS | QUANTITY | REFILLS |
|---|---|---|---|---|
| Exa-Cel (Exagamglogene Autotemcel) | | | | |

## Clinical Information

***** *Please submit supporting clinical documentation* *****

***THERAPY TYPE (choose one):** ☐INITIAL THERAPY ☐CONTINUATION OF THERAPY

Therapy start date: _____

1. Is therapy prescribed by or in consultation with a hematologist and transplant specialist?
   ☐Yes, hematologist and transplant specialist ☐Yes, hematologist ☐Yes, transplant specialist ☐No
2. Please indicate patient's genotype. ***Mark all that apply***
   ☐$\beta^0/\beta^0$ ☐$\beta^+/\beta^+$ ☐$\beta^0/\beta^+$ (not IVS-1-110) ☐$\beta^0/\beta^+$ (IVS1-110) ☐$\beta^E/\beta^+$ ☐$\beta^E/\beta^0$ ☐$\beta^S/\beta^S$ ☐$\beta^S/\beta^0$
   ☐Other: _____
3. Does transplant specialist attest patient understands the risk and benefits of alternative therapeutic options such as allogenic hematopoietic stem cell transplantation (HSCT)? ☐Yes ☐No
4. Does transplant specialist attest patient is clinically stable and eligible to undergo myeloablative conditioning and HSCT?
   ☐Yes ☐No
5. Has patient received prior allogenic HSCT or gene therapy? ☐Yes ☐No
6. How many Exa-Cel infusions has patient received? ☐0 ☐1 or more
7. **For TDT**, is there documentation of receipt of ≥ 100 mL/kg or 10 units of packed red blood cells (pRBC) per year during the previous 2 years? ☐Yes ***Answer a and b below*** ☐No
   a. Date: _____, _____ mL/kg or _____ units pRBC
   b. Date: _____, _____ mL/kg or _____ units pRBC
8. **For SCD**, is there documentation of ≥ 2 severe vaso-occlusive episodes per year during the previous 2 years?
   ☐Yes ***Answer a and b below*** ☐No
   a. Year date: _____, # of severe vaso-occlusive episodes: _____
   b. Year date: _____, # of severe vaso-occlusive episodes: _____

**Complete this section ONLY for indications <u>other</u> than TDT or SCD:**

9. Has patient tried and failed, or is contraindicated to, accepted standards of care? ☐Yes ☐No
   ***If yes, submit documentation and answer the following:***
   a. Please list all previous therapies: _____
   b. Was patient adherent to previously tried therapies? ☐Yes ☐No ☐No, patient intolerant to drug

**Please continue to page 2.**

# Exagamglogene Autotemcel (Exa-Cel)

## Prior Authorization Form/Prescription

peach state health plan

**Telephone: (800) 514-0083 option 2**
**Fax: (866) 374-1579**

Date: _____ Date Medication Required: _____
Ship to: ❍ Physician ❍ Patient's Home ❍ Other _____

**Patient Name:** _____ **DOB:** _____

**Physician's Signature** _____ **Date:** _____ ☐ **DAW**

## INFORMATION BELOW IS TO BE COMPLETED BY THE HEALTH PLAN / CPS PA STAFF

**Authorization Information**

| | |
|---|---|
| ***Authorization number:** | ***Decision Due Date:** |
| ***J-Code:** | **Coverage:** ☐State excludes ☐COB (secondary) |
| ***Line of Business:** ☐Commercial ☐Health Insurance Marketplace ☐Medicaid ☐Medicare | ***Benefit:** ☐Medical ☐Pharmacy |

***Choose one criteria option below based on line of business:**

**Medicare Criteria Only:**

☐Medicare Local Coverage Decision (LCD) specific for your region
Please include policy of link to LCD, followed by any applicable Medicare Part B step therapy requirements in MCPB.ST.00.

☐Medicare National Coverage Decision (NCD). _____
Please include policy of link to NCD, followed by any applicable Medicare Part B step therapy requirements in MCPB.ST.00.

_____

**Medicaid, Commercial, Exchange (Ambetter) Criteria:**

☐Centene Policy [**CP.PHAR.603 Exagamglogene Autotemcel (Exa-Cel)**]
Date Policy last reviewed/approved by plan (we want to be sure we are using the version approved by your plan): _____

***OR***

☐State or Health Plan Specific (please include policy) _____