Lovotibeglogene Autotemcel (Lyfgenia)

Prior Authorization Form/Prescription

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: ____

☐Sickle cell disease (SCD) ☐Other: ______________________________

Prescription Information

MEDICATION	STRENGTH	*DIRECTIONS	QUANTITY	REFILLS
Lovo-Cel (Lovotibeglogene 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***
   ☐β^S/β^S ☐β^S/β^0 ☐β^S/β^+ ☐Other: ______________________
3. Has patient experienced at least 1 vaso-occlusive crisis (VOC*) within the past 6 months while on hydroxyurea at up to maximally indicated doses? ☐Yes ☐No ☐Contraindicated/intolerant
   a. *If yes*, please provide date(s) of VOC: ____
   b. *If contraindicated/intolerant*, has patient experienced at least 2 VOC within the past 12 months? ☐Yes ☐No
      i. *If yes*, please provide date(s) of VOC: ____

   **VOC is defined as a previously documented episode of acute painful crisis or acute chest syndrome (ACS) for which there was no explanation other than VOC that required prescription or healthcare professional-instructed use of analgesics for moderate to severe pain.*
4. Does patient have contraindication or intolerance to hydroxyurea?
   ☐Yes ☐No
   a. *If contraindicated/intolerant*, please describe: ____
   ____
   ____
5. Does transplant specialist attest patient understands the risk and benefits of alternative therapeutic options such as allogenic hematopoietic stem cell transplantation (HSCT)? ☐Yes ☐No
6. Does transplant specialist attest patient is clinically stable and eligible to undergo myeloablative conditioning and HSCT?
   ☐Yes ☐No
7. Has patient received prior allogenic HSCT or gene therapy? ☐Yes ☐No
8. Does patient have 2 α-globin gene deletions (e.g., alpha-thalassemia trait)? ☐Yes ☐No
9. How many Exa-Cel infusions has patient received? ☐0 ☐1 or more

Please continue to page 2.

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Patient Name: ______________________________ **DOB:** ______________

Complete this section ONLY for indications other than SCD:

10. 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

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.627 Lovotibeglogene Autotemcel (Lovo-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)