



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

Skysona™ (elivaldogene 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

1. Is the patient a male at least four years of age but less than 18 years of age? Yes No
2. Is the diagnosis early, active cerebral adrenoleukodystrophy (CALD)? Yes No
3. Provide very-long-chain fatty acids (VLCFA) values and documentation:
 - C26:0, 1.30 + 0.45 (normal: 0.23 + 0.09): _____
 - C24:0/C22:0, 1.71 + 0.23 (normal: 0.84 + 0.10): _____
 - C26:0/C22:0, 0.07 + 0.03 (normal: 0.01 + 0.004): _____
4. Provide genetic testing results showing *ABCD1* mutation.

(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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PATIENT LAST NAME:

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PATIENT FIRST NAME:

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SECTION III: CLINICAL HISTORY (*Continued*)

5. Does the patient have active central nervous system (CNS) disease established by a central radiographic review of brain magnetic resonance imaging (MRI)? Yes No
 - Provide Loes score: _____ (34-point scale)
 - Does the MRI show demyelinating lesions with gadolinium enhancement? Yes No
6. What is the patient's neurological function score (NFS)? _____
7. Has the patient has been screened for the following conditions? Yes No
 - hepatitis B virus (HBV)
 - hepatitis C virus (HCV)
 - human T-lymphotrophic virus 1 and 2 (HTLV-1/HTLV-2)
 - human immunodeficiency virus 1 and 2 (HIV-1/HIV-2)
8. Does the patient have an active infection, including clinically important localized infections? Yes No
9. Will prophylaxis for infection be followed according to standard institutional guidelines? Yes No
10. Is the patient up to date with all age-appropriate vaccinations, in accordance with current vaccination guidelines? Yes No
11. Do you attest that the patient will receive periodic, life-long monitoring for hematological malignancies? Yes No
12. Will anti-retroviral medications be avoided one month prior to and throughout all cycles of apheresis? Yes No
13. Does the patient have head trauma induced disease? Yes No
14. Will Skysona be used to prevent the development of or treat adrenal insufficiency? Yes No
15. Has the patient had a hematopoietic stem cell transplant? Yes No
16. Does the patient have a known or available human leukocyte antigen (HLA)-matched willing family donor? Yes No

(Form continued on next page.)





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PATIENT FIRST NAME:

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SECTION III: CLINICAL HISTORY (Continued)

Please 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: _____

