



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:
 - a. C26:0, 1.30 + 0.45 (normal: 0.23 + 0.09): _____
 - b. C24:0/C22:0, 1.71 + 0.23 (normal: 0.84 + 0.10): _____
 - c. 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 Magellan Rx Management if medications will be dispensed by a pharmacy and will be administered by the patient or caregiver at home.

Phone: 1-866-675-7755

Fax: 1-888-603-7696

Fax to DHHS if medication is dispensed/administered by the office or outpatient setting:

Phone: 1-603-271-9384

Fax: 1-603-271-8194



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DATE OF MEDICATION REQUEST: / /

PATIENT LAST NAME:

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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: _____

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