



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

Zynteglo® (betibeglogene autotemcel)

DATE OF MEDICATION REQUEST: / /

SECTION I: PATIENT INFORMATION AND MEDICATION REQUESTED

LAST NAME:

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FIRST NAME:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

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

- Is the patient at least 4 years of age? Yes No
- Does the patient have a documented diagnosis of beta thalassemia that has been confirmed by the following? Yes No
 - Beta-globin gene (HBB) sequence gene analysis showing biallelic pathogenic variants
 - Peripheral blood smear and hemoglobin analysis revealing decreased amounts or complete absence of hemoglobin A and increased amounts of hemoglobin F
- Does the patient have transfusion-dependent disease as defined by the following criteria? Yes No
 - transfusions of at least 100 mL/kg/year of packed red blood cells (pRBCs)
 - 8 or more transfusions of pRBCs per year in the 2 years preceding therapy

(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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