

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:	FIRST NAME:											
MEDICAID ID NUMBER:	DATE OF BIRTH:											
GENDER: Male Female		,										
Drug Name:	Strength:											
Dosing Directions:	Length of Therapy:											
SECTION II: PRESCRIBER INFORMATION												
LAST NAME:	FIRST NAME:											
SPECIALTY:	NPI NUMBER:											
PHONE NUMBER:	FAX NUMBER:											
SECTION III: CLINICAL HISTORY												
1. Is the patient at least 4 years of age?		Yes No										
2. Does the patient have a documented diagnosis of be the following?	eta thalassemia that has been confirmed b	oy Yes No										
 Beta-globin gene (HBB) sequence gene analysis Peripheral blood smear and hemoglobin analysis absence of hemoglobin A and increased amount 	revealing decreased amounts or complet	te										
3. Does the patient have transfusion-dependent diseas	se as defined by the following criteria?	Yes No										
 transfusions of at least 100 mL/kg/year of packet 	d 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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		ı	DATE O	F MEDI	CATION	N REQU	IEST:		/		/													
LA	ST N	IAME:											FIRS	ΓΝΑΙ	ME:									
SE	CTIC	ON III:	CLINI	CAL	HIST	ORY	(Con	tinu	ed)															
4.	Do	es the p	oatie	nt ha	ve ar	ny of	the	follo	wing	cond	dition	ıs?)									Ye	es [No
		Severely elevated iron in the heart (e.g., patients with cardiac T2* less than 10 msec by magnetic resonance imaging [MRI]) Advanced liver disease Patients with an MRI of the liver with results demonstrating liver iron content 15 mg/g or more (unless biopsy confirms absence of advanced disease)																						
	•													_	IVCI II	011 0	Onicci	10 13	1116/	g 01				
5. Has the patient has been screened for the following conditions?														Ye	es [] No								
	•	hepati	tis B	virus	(HB)	/)																		
	•	hepati	tis C	virus	(HC\	/)																		
	•	humar	า T-ly	mph	otrop	ohic	virus	1 an	d 2 (HTLV	/-1/H	TL'	.V-2)											
	•	humar	n imn	nuno	defic	ienc	y viru	ıs 1 a	and 2	2 (HI\	/-1/H	I۷	-2)											
6.						catio	ns ar	nd hy	/dro>	kyure	ea be	av	oided	one	mon	th pr	ior to	and	thro	ughc	out	Ye	es [☐ No
7.						py b	e disc	conti	inue	d for	7 or ı	nc	ore da	ys pr	ior to	initi	ating	mye	eloab	lative	9	Ye	es [No
8.			-				-			_									-			Ye	es [] No
9.	Wil	l Zynte	glo®	be us	sed a	s a s	ingle	-age	nt th	erap	y?											Ye	es [No
10		•		hat t	he pa	atien	t wil	l rece	eive	perio	dic, l	ife	e-long	mon	itorir	ng for	hem	atol	ogica	I		Ye	es [_ No
11	. Is t	he pati	ent e	ligibl	e to	unde	ergo l	hem	atop	oietio	c sten	n c	cell tra	anspl	ant (I	HSCT)?					Ye	es [No
12	. Has	the pa	atient	t had	a he	mate	opoie	etic s	tem	cell t	rans	ola	ant?									Ye	es [No

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(Form continued on next page.)





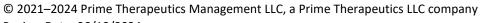
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LAST	NA	ME:									_	FIRS	ΓΝΑ	ME:									
SEC	ΓΙΟΝ	I III: CLII	NICAL	HIST	ORY	(Con	tinu	ed)									·						
Prov	ide a	ny addi	tional	infor	mati	on th	nat w	vould	l help	o in tl	he (decis	ion-n	naki	ng pı	roce	ess. If	additi	onal :	space	e is ne	eeded	1,
plea	se us	se a sep	arate	sheet																			
	-	hat the			-							-					-		_				d
PRES	CRIE	BER'S SI	GNAT	URE:														DAT	Έ:				
Facil	ity w	here in	fusion	to be	e pro	vide	d:																
Med	icaid	l Provid	er Nur	nber	of Fa	cility	/ :																

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Review Date: 06/10/2024

