Clinical Criteria Worksheet:
Hemgenix® (etranacogene dezaparvovec-drlb)

Enrollee Information

Enrollee Last Name: _____

Enrollee First Name: _____

Date of Birth (MM/DD/YYYY): ☐☐ / ☐☐ / ☐☐☐☐

Enrollee Medicaid ID (2 letters, 5 numbers, 1 letter): ☐☐☐☐☐☐☐☐☐

Address: _____

City, Town or Post Office: _____ **State:** _____ **ZIP Code:** _____

Prescriber Information

Prescriber Last Name: _____

Prescriber First Name: _____

National Provider Identifier (NPI) Number: _____

Preferred Contact (Telephone Number): _____

Drug Information

Drug Administration:

Provide the date of drug administration (MM/DD/YYYY):
☐☐ / ☐☐ / ☐☐☐☐

Provide the expiration date of the drug if the invoice date is greater than six (6) months from the date of drug administration (MM/DD/YYYY):
☐☐ / ☐☐ / ☐☐☐☐

Clinical Criteria

1. Does the patient have a congenital hemophilia B?

☐ Yes ☐ No

Enrollee Last Name: **Enrollee First Name:**

_____ _____

2. Does the patient have moderately severe or severe hemophilia B?

   ☐ Yes ☐ No

3. Does the patient have a history of Factor IX inhibitors?

   ☐ Yes ☐ No

4. Did the patient have a positive Factor IX inhibitor test?

   ☐ Yes ☐ No

5. Has the patient received any previous treatment with Hemgenix®?

   (Hemgenix® treatment is limited to one treatment per patient for their lifetime.)

   ☐ Yes ☐ No

Attestation

I attest that this is medically necessary for this patient and that all of the information on this form is accurate to the best of my knowledge. I attest that documentation of the above diagnosis and medical necessity is available for review if requested by the New York State Medicaid Program.

_____ _____

Prescriber Signature (Required) **Date (MM/DD/YYYY)**