Clinical Criteria Worksheet:
Skysona® (elivaldogene autotemcel)

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): _____

Clinical Criteria

Drug Administration:

Provide the date 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):

| | | / | | | / | | | | |

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

_____ _____

Clinical Criteria

1. Does the patient have a diagnosis of early, active cerebral adrenoleukodystrophy (CALD)?

   ☐ Yes ☐ No

2. Is the patient a candidate for allogeneic hematopoietic stem cell transplantation (HSCT), but ineligible due to the absence of a donor?

   ☐ Yes ☐ No

3. Does the patient have human immunodeficiency virus (HIV) or human T-lymphotropic virus (HTLV)?

   ☐ Yes ☐ No

4. Has the patient discontinued anti-retroviral medications for at least one month prior to initiating medications for stem cell mobilization and for the expected duration for elimination of the medications, and until all cycles of apheresis are completed ?

   ☐ Yes ☐ No

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

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

   ☐ Yes ☐ No

Attestation

I attest that this drug 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)**