Clinical Criteria Worksheet:
Zynteglo® (betibeglogene 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): _____

Pharmacy Information (if dispensed by a pharmacy)

Pharmacy Name: _____

National Provider Identifier (NPI) Number: _____

Preferred Contact (Telephone Number): _____

Drug Information

Drug Administration:

Provide the date or expected 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 the drug was administered (MM/DD/YYYY):

☐☐ / ☐☐ / ☐☐☐☐

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

_____ _____

Clinical Criteria

1. Does the patient have a diagnosis of transfusion-dependent beta-thalassemia?

   Transfusion-depended beta-thalassemia is defined as a history of at least 100 mL/kg/year of packed red blood cells (pRBC) in the two (2) years preceding administration of betibeglogene autotemcel or with greater than or equal to eigh (8) transfusions of pRBCs per year in the two (2) years preceding administration of betibeglogene autotemcel.

   ☐ Yes ☐ No

2. Is the patient a candidate to undergo allogeneic hematopoietic cell transplantation, but ineligible due to the absence of a suitable donor?

   ☐ Yes ☐ No

3. Is the patient less than or equal to fifty (50) years of age?

   ☐ Yes ☐ No

4. Is the patient less than five (5) years of age?

   ☐ Yes ☐ No

   If Yes, does the patient weigh greater than or equal to six (6) kilograms? **(Zynteglo® is not covered for patients less than four [4] years of age regardless of weight)**

   ☐ Yes ☐ No

5. Is the patient on any anti-retroviral medications

   ☐ Yes ☐ No

6. Has the patient received any previous treatment with Zynteglo®?

   (Zynteglo® 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)**