Medicaid Managed Care Plan Clinical Criteria Worksheet: Zynteglo® (betibeglogene autotemcel)

Claim Submission

- Prior Authorization may be delayed if the information submitted in this worksheet is illegible.
- If the worksheet is left blank or information is missing the prior authorization will be rejected for not enough documentation.
- Once completed the worksheet will be sent via **SECUR**E email to NYRX@health.ny.gov

Medicaid Managed Care Plan Name

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)

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Enrollee Last Name:

Enrollee First Name:

Pharmacy Information

Pharmacy Name:

Phone number:

National Provider Identifier (NPI) Number:

Enrollee Last Name: | | | | | | | | | | | | |

Enrollee First Name: | | | | | | | | | | | | |

Clinical Criteria – Drug Information

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

☐☐ / ☐☐ / ☐☐☐☐

Criteria – Clinical

1. Has the patient been approved for the coverage of medical care associated with Zynteglo® therapy?

   ☐ Yes ☐ No

2. 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 eight (8) transfusions of pRBCs per year in the two(2) years preceding administration of betibeglogene autotemcel.

   ☐ Yes ☐ No

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

   ☐ Yes ☐ No

Enrollee Last Name: | | | | | | | | | | | | |

Enrollee First Name: | | | | | | | | | | | | |

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

☐ Yes ☐ No

5. 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?

☐ Yes ☐ No

(Zynteglo® is not covered for patients less than four [4] years of age regardless of weight)

6. Is the patient on any anti-retroviral medications?

☐ Yes ☐ No

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

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

☐ Yes ☐ No

8. Is the therapy for a medically accepted indication and medically necessary?

☐ Yes ☐ No

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

Attestation

I attest that all of the information on this form is accurate to the best of my knowledge and is available for review if requested by the New York State Medicaid Program.

Managed Care Plan Representative

Last Name: **First Name:**

Date (MM/DD/YYYY)

/ /

Once completed the worksheet must be submitted via **SECUR**E email to NYRX@health.ny.gov

NOTE: A Medicaid Managed Care Plan representative should notify the NYRx program via SECURE email at NYRx@health.ny.gov once the target number of CD34+ cells have been collected for Zynteglo® manufacturing.