Reset Form Print Form

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 beta thalassemia that has been confirmed by the following? ☐ Yes ☐ No
   - Beta-globin gene (HBB) sequence gene analysis showing biallelic pathogenic variants
   - Peripheral blood smear and hemoglobin analysis revealing decreased amounts or complete absence of hemoglobin A and increased amounts of hemoglobin F
3. Does the patient have transfusion-dependent disease as defined by the following criteria? ☐ Yes ☐ No
   - transfusions of at least 100 mL/kg/year of packed 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

Review Date: 06/10/2024

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SECTION III: CLINICAL HISTORY *(Continued)*

4. Does the patient have any of the following conditions? ☐ Yes ☐ 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)
5. Has the patient has been screened for the following conditions? ☐ Yes ☐ No
   - hepatitis B virus (HBV)
   - hepatitis C virus (HCV)
   - human T-lymphotrophic virus 1 and 2 (HTLV-1/HTLV-2)
   - human immunodeficiency virus 1 and 2 (HIV-1/HIV-2)
6. Will anti-retroviral medications and hydroxyurea be avoided one month prior to and throughout all cycles of apheresis? ☐ Yes ☐ No
7. Will iron chelation therapy be discontinued for 7 or more days prior to initiating myeloablative conditioning therapy? ☐ Yes ☐ No
8. Has pregnancy been ruled out prior to starting mobilization and will lack of pregnancy be re-confirmed prior to conditioning procedures and again before administration of Zynteglo®? ☐ Yes ☐ No
9. Will Zynteglo® be used as a single-agent therapy? ☐ Yes ☐ No
10. Do you attest that the patient will receive periodic, life-long monitoring for hematological malignancies? ☐ Yes ☐ No
11. Is the patient eligible to undergo hematopoietic stem cell transplant (HSCT)? ☐ Yes ☐ No
12. Has the patient had a hematopoietic stem cell transplant? ☐ Yes ☐ No

(Form continued on next page.)

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SECTION III: CLINICAL HISTORY *(Continued)*

Provide any additional information that would help in the decision-making process. If additional space is needed, please use a separate sheet.

I certify that the information provided is accurate and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

PRESCRIBER'S SIGNATURE: _____ **DATE**: _____

Facility where infusion to be provided: _____

Medicaid Provider Number of Facility: _____

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