



LYFGENIA (lovotibeglogene autotemcel) PRIOR AUTHORIZATION FORM (form effective 1/5/2026)

Prior authorization guidelines for **Lyfgenia (lovotibeglogene autotemcel)** are available on the DHS Pharmacy Services website at <https://www.pa.gov/agencies/dhs/resources/for-providers/ma-for-providers/pharmacy-services>.

Beneficiary name:	Beneficiary ID#:	Beneficiary DOB:
Prescriber name:	Prescriber NPI:	
Prescriber address (street/city/state/zip):		
Prescriber specialty:	Prescriber phone:	Prescriber fax:
Office contact name:	Office contact phone:	Office contact fax:
Service provider name:	Service provider MA ID:	
Service provider address (street/city/state/zip):		

Drug name: Lyfgenia	Beneficiary's weight (kg):	Dose: _____ x 10 ⁶ CD34+ cells/kg
Place of service:	Anticipated date of infusion:	
Diagnosis (submit documentation):	Dx code (required):	HCPCS code (required):

Check all that apply and submit documentation (e.g., recent chart/clinic notes, diagnostic evaluations, test results, etc.) for each item.

- Is clinically stable for transplantation based on the prescriber's assessment.
- Has NOT received a prior allogeneic hematopoietic stem cell transplant.
- Has sickle cell disease with confirmatory genetic testing.
- At least one of the following:
 - Has a history of vaso-occlusive episodes (e.g., pain crises, acute chest syndrome, splenic sequestration, priapism) that required a medical facility visit (e.g., emergency department, hospital).
 - Is currently receiving chronic transfusion therapy for recurrent vaso-occlusive episodes.

PLEASE FAX COMPLETED FORM WITH SUPPORTING CLINICAL DOCUMENTATION TO DHS at 717-265-8289.

Prescriber Signature:	Date:
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