Office of Medical Assistance Programs
Bureau of Fee-for-Service Programs, Pharmacy Division
Phone 1-800-537-8862 Fax 717-265-8289

pennsylvania
DEPARTMENT OF HUMAN SERVICES

CASGEVY (exagamglogene autotemcel) PRIOR AUTHORIZATION FORM *(form effective 7/15/2024)*

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

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:
Billing provider name:		Billing provider NPI:
Billing provider address:		

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

Complete the sections below that apply to the beneficiary and this request.
Check all that apply and submit documentation (e.g., recent chart notes, diagnostic evaluations, test results, etc.) for each item.

1. **For ALL DIAGNOSES:**
   - ☐ Has NOT received prior gene therapy.
   - ☐ Has NOT received a prior allogeneic hematopoietic stem cell transplant.
2. **For the treatment of SICKLE CELL DISEASE:**
   - ☐ Has sickle cell disease with **a βS/βS, βS/β0, or βS/β+ genotype**.
   - ☐ 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.
3. **For the treatment of TRANSFUSION-DEPENDENT β-THALASSEMIA:**
   - ☐ Has genetic testing confirming the diagnosis of β-thalassemia.
   - ☐ Has a history of at least 100 mL/kg/year or 8 transfusion episodes/year of packed red blood cell transfusions in the prior 2 years.

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

Prescriber Signature:	Date:

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