pennsylvania
DEPARTMENT OF HUMAN SERVICES

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

LYFGENIA (lovotibeglogene autotemcel) PRIOR AUTHORIZATION FORM *(form effective 7/15/2024)*

Prior authorization guidelines for Lyfgenia (lovotibeglogene 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: 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*):

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

- ☐ Has NOT received prior gene therapy.
- ☐ Has NOT received a prior allogeneic hematopoietic stem cell transplant.
- ☐ 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.

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

Prescriber Signature:	Date: