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

ZYNTEGLO (betibeglogene autotemcel) PRIOR AUTHORIZATION FORM *(form effective 7/15/2024)*

Prior authorization guidelines for **Zynteglo (betibeglogene 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: Zynteglo	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 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:

Confidentiality Notice: The documents accompanying this telecopy may contain confidential information belonging to the sender. The information is intended only for the use of the individual named above. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or taking of any telecopy is strictly prohibited.