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WEB: [DSS Medicaid Prior Authorizations](#) | EMAIL : DSSMedicaidpa@state.sd.us

CASGEVY PRIOR AUTHORIZATION REQUEST FORM

Use this form when therapy is requested for beta-thalassemia

This form **MUST BE** submitted with medical records to support services

Date:		
RECEIPT INFORMATION		
Medicaid ID:	Date of Birth:	Sex: M F
Last Name:		First Name:
GENERAL INFORMATION		
First Date of Service:		Last Date of Service:
Primary Diagnosis Code:		HCP Code:
Drug Name:		Dose & Frequency:
Hospitalizations/Treatments/Medications Used in the last 6 months:		
POINT OF CONTACT		
Name and Title:		
Email:	Phone:	Fax:
<small><i>Note: The point of contact is the individual completing the PA and would be the contact for questions SD Medicaid may have regarding the PA. The determination notice will be sent to the listed point of contact.</i></small>		
REFERRING PROVIDER INFORMATION		
Name:		
NPI #:		Taxonomy:
Phone:		Fax:
SERVICING PROVIDER INFORMATION		
Name:		
Address:		
NPI #:		Taxonomy:
Phone:		Fax:

CRITERIA		
Medical records to support use of product are submitted		
Initial Therapy (check one)	Yes	No
	Therapy is prescribed by a hematologist	
	Individual has a diagnosis of beta thalassemia with a β^0/β^0 , β^0/β^0 -like or non- β^0/β^0 -like genotype	
	Individual does not have associated α -thalassemia and >1 alpha deletion, or alpha multiplications	
	Individual is transfusion-dependent as defined by a history of ≥ 100 ml/kg/year or 10 units of packed red blood cell (RBC) transfusions/year in the prior 24 months before therapy request	
	Attestation from provider that member is clinically stable and able to undergo gene therapy	
	Individual does not have a known, human leukocyte antigen (HLA)-matched donor	
	Screening has been done within the last 6 months and documentation is provided indicating that the individual is negative for the following active diseases: HIV, Hepatitis B, and Hepatitis C	
	Individual has not previously received a hematopoietic stem cell transplant or prior gene therapy	
	Individual does not have advanced liver disease (defined as ALT >3X upper limit of normal, direct bilirubin >2.5x upper limit of normal, baseline prothrombin time >1.5x upper limit of normal or history of cirrhosis or any evidence of bridging fibrosis, or active hepatitis on liver biopsy)	
	If female, documentation of negative pregnancy test must be submitted prior to therapy	
	Male and female members of reproductive potential must use an effective method of contraception at start of treatment and at least 6 months following Casgevy administration	
	Individual is 12-35 years of age	
PHYSICIAN SIGNATURE – PROVIDER ONLY		
This form <u>must be</u> signed by a provider		
	I certify that the information given in this form is a true and accurate medical indication for the required product	
Name & Title (Printed):		Specialty:
Signature:		