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## LYFGENIA PRIOR AUTHORIZATION REQUEST FORM

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

Date:		
<b>RECEIPIENT INFORMATION</b>		
Medicaid ID:	Date of Birth:	Sex:    M            F
Last Name:		First Name:
<b>GENERAL INFORMATION</b>		
First Date of Service:		Last Date of Service:
Primary Diagnosis Code:		HCPC Code:
Drug Name:		Dose & Frequency:
Hospitalizations/Treatments/Medications Used in the last 6 months:		
<b>POINT OF CONTACT</b>		
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>		
<b>REFERRING PROVIDER INFORMATION</b>		
Name:		
NPI #:		Taxonomy:
Phone:		Fax:
<b>SERVICING PROVIDER INFORMATION</b>		
Name:		
Address:		
NPI #:		Taxonomy:
Phone:		Fax:

<b>CRITERIA</b>		
<b>Medical records to support use of product are submitted</b>		
<b>Initial Therapy (check one)</b>	<b>Yes</b>	<b>No</b>
	Therapy is prescribed by a hematologist	
	Individual has a diagnosis of SCD with a $\beta^S/\beta^S$ genotype	
	Documentation is provided that the individual has had $\geq 4$ *severe VOEs (as defined below), while receiving appropriate supportive care, for the previous 24 months prior to therapy request	
	Individual has a documented failure (or contraindication) of $\geq 6$ months with hydroxyurea within the last 24 months	
	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 aspartate transaminase, alanine transaminase or direct bilirubin $>3x$ the upper limit of normal or baseline prothrombin time or partial thromboplastin time $>1.5x$ upper limit of normal, or MRI of the liver demonstrating evidence of cirrhosis or active hepatitis or fibrosis)	
	Individual does not have $\geq 2$ $\alpha$ -globin gene deletions (i.e., alpha-thalassemia trait)	
	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 Lyfgenia administration	
	Individual is 12-50 years of age	
<b>PHYSICIAN SIGNATURE – PROVIDER ONLY</b>		
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	
<b>Name &amp; Title (Printed):</b>		<b>Specialty:</b>
<b>Signature:</b>		