

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



Fax to PerformRxSM at **1-888-981-5202**, or to speak to a representative call **1-866-610-2774**.

BENEFICIARY INFORMATION		
Beneficiary name:	Beneficiary ID#:	DOB:
PRESCRIBER INFORMATION		
Prescriber name:		
Specialty:	NPI:	
Prescriber address (street/city/state/zip):		
Prescriber phone:	Prescriber fax:	
OFFICE CONTACT INFORMATION		
Office contact name:		
Office contact phone:	Office contact fax:	
BILLING PROVIDER INFORMATION		
Billing provider name:	Billing provider NPI:	
Billing provider address:		
CLINICAL INFORMATION		
Drug name: Casgev	Beneficiary's weight (kg):	Dose: _____ x 10 ⁶ CD34+ cells/kg
Place of service:	Anticipated date of infusion:	
Diagnosis (submit documentation):	Dx code (required):	
INITIAL REQUESTS		
<p>Complete all sections that apply to the beneficiary and this request. Check all that apply and <i>submit documentation</i> (e.g., recent chart/clinic notes, diagnostic evaluations, test results) for each item.</p>		
<p>1. For ALL DIAGNOSES:</p> <p><input type="checkbox"/> Has NOT received prior gene therapy.</p> <p><input type="checkbox"/> Has NOT received a prior allogeneic hematopoietic stem cell transplant.</p>		
<p>2. For the treatment of SICKLE CELL DISEASE:</p> <p><input type="checkbox"/> Has sickle cell disease with a BS/BS, BS/BO, or BS/B+ genotype.</p> <p><input type="checkbox"/> At least <u>one</u> of the following:</p> <p style="padding-left: 20px;"><input type="checkbox"/> 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).</p> <p style="padding-left: 20px;"><input type="checkbox"/> Is currently receiving chronic transfusion therapy for recurrent vaso-occlusive episodes.</p>		
<p>3. For the treatment of TRANSFUSION-DEPENDENT B-THALASSEMIA:</p> <p><input type="checkbox"/> Has genetic testing confirming the diagnosis of B-thalassemia.</p> <p><input type="checkbox"/> 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.</p>		
PLEASE FAX COMPLETED FORM WITH SUPPORTING CLINICAL DOCUMENTATION		
Prescriber signature:	Date:	

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