ZYNTEGLO (betibeglogene autotemcel) PRIOR AUTHORIZATION FORM

(form effective 7/15/2024)

Fax to PerformRx[SM] 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: 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)*:

INITIAL REQUESTS

Check all that apply and <u>submit documentation</u> (e.g., recent chart/clinic notes, diagnostic evaluations, test results) 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 ß-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

Prescriber signature:	Date:

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