SENTARA COMMUNITY PLAN
(MEDICAID)

MEDICAL PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-844-305-2331**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If information provided is not complete, correct, or legible, authorization can be delayed**.

Drug Requested: Casgevy™ (exagamglogene autotemcel) **(J3392) (Medical)**

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member Sentara #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Name/Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight (if applicable): _____ **Date weight obtained:** _____

❑ Standard Review. In checking this box, the timeframe does not jeopardize the life or health of the member or the member's ability to regain maximum function and would not subject the member to severe pain.

Dosing Limits

A. Quantity Limit (max daily dose) [NDC Unit]:

- Casgevy is supplied in one or more vials (one carton contains a single lot consisting of 1 to 9 vials) containing a frozen suspension of genome edited autologous CD34+ cells in a cryo-preservative medium containing 5% DMSO and dextran 40 **[NDC 51167-290-09]**
- The minimum recommended dose of Casgevy is 3×10^6 CD34+ cells per kg of body weight
- Requests for subsequent use of exagamglogene after receipt of other gene therapies (e.g., lovotibeglogene, betibeglogene) will be evaluated on a case-by-case basis

B. Max Units (per dose and over time) [HCPCS Unit]:

- One treatment (dose) per lifetime

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CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

Authorization Criteria: Coverage will be provided for one treatment course (1 dose of Casgevy) and may NOT be renewed.

- ❑ Member is 2 years of age or older
- ❑ Member has had either genetic testing or hemoglobin fractionation to confirm a diagnosis of sickle cell disease
- ❑ Member has history of use or intolerance to hydroxyurea (per health care professional judgement) at any point in the past
- ❑ Member is clinically stable and fit for transplantation
- ❑ CGT Product is prescribed in consultation with a board-certified hematologist with SCD (sickle cell disease) expertise
- ❑ Member has experienced recurrent VOCs (vaso-occlusive crisis) (defined as more than or equal to two (2) documented VOCs per year in the previous twenty-four (24) months, based on provider attestation)

Medication being provided by: Please check applicable box below.

- ❑ **Location/site of drug administration:** _____

  NPI or DEA # of administering location: _____

  OR

- ❑ **Specialty Pharmacy – PropriumRx**

For urgent reviews: Practitioner should call Sentara Health Pre-Authorization Department if they believe a standard review would subject the member to adverse health consequences. Sentara Health's definition of urgent is a lack of treatment that could seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

*****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.*****

****Previous therapies will be verified through pharmacy paid claims or submitted chart notes.****

***Approved by Pharmacy and Therapeutics Committee**: ~~1/18/2024;~~ **11/21/2024**
REVISED/UPDATED/REFORMATTED: ~~2/9/2024; 11/19/2024; 6/8/2026;~~ **8/11/2026**