ZYNTEGLO (betibeglogene autotemcel) PRIOR AUTHORIZATION FORM

(form effective 7/15/2024)

Community HealthChoices | AmeriHealth Caritas Pennsylvania | PERFORMRx℠ Next Generation Pharmacy Benefits

Fax to PerformRx℠ at **1-855-851-4058**, or to speak to a representative call **1-888-674-8720**.

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 submit documentation (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: