Casgevy™ (exagamglogene autotemcel) Medication Precertification Request

(All fields must be completed and legible for precertification review.)

Aetna Precertification Notification
Phone: 1-866-752-7021 (TTY: 711)
FAX: 1-888-267-3277

For Medicare Advantage Part B:
Please Use Medicare Request Form

Please indicate: ☐ Start of treatment: Start date ____/____/____
☐ Continuation of therapy, Date of last treatment ____/____/____

Precertification Requested By: _____ Phone: _____ Fax: _____

A. PATIENT INFORMATION

First Name:	Last Name:	DOB:	
Address:	City:	State:	ZIP:
Home Phone:	Work Phone:	Cell Phone:	Email:
Patient Current Weight: ____ lbs or ____ kgs Patient Height: ____ inches or ____ cms		Allergies:	

B. INSURANCE INFORMATION

Aetna Member ID #: _____
Group #: _____
Insured:

Does patient have other coverage? ☐ Yes ☐ No
If yes, provide ID#: _____ Carrier Name: _____
Insured:

Medicare: ☐ Yes ☐ No If yes, provide ID #: **Medicaid:** ☐ Yes ☐ No If yes, provide ID #:

C. PRESCRIBER INFORMATION

First Name:		Last Name: *(Check One):* ☐ M.D. ☐ D.O. ☐ N.P. ☐ P.A.			
Address:		City:		State:	ZIP:
Phone:	Fax:	St Lic #:	NPI #:	DEA #:	UPIN:
Provider Email:		Office Contact Name:		Phone:	

Specialty *(Check one):* ☐ **Hematologist** ☐ **Other**: _____

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration:
☐ Self-administered ☐ Physician's Office
☐ Outpatient Infusion Center Phone: _____
Center Name: _____
☐ Home Infusion Center Phone: _____
Agency Name: _____
☐ Administration code(s) (CPT): _____
Address: _____

Dispensing Provider/Pharmacy: *Patient Selected choice*
☐ Physician's Office ☐ Retail Pharmacy
☐ Specialty Pharmacy ☐ Other
Name: _____
Address: _____
Phone: _____ Fax: _____
TIN: _____ PIN: _____

E. PRODUCT INFORMATION

Request is for: Casgevy (exagamglogene autotemcel) Dose: _____ **Frequency:** _____

F. DIAGNOSIS INFORMATION - Please indicate primary ICD code and specify any other where applicable.

Primary ICD Code: ☐ _____ **Secondary ICD Code :** _____ **Other ICD Code:** _____

G. CLINICAL INFORMATION - Required clinical information must be completed in its entirety for all precertification requests.

For ALL Requests (clinical documentation required):

☐ Yes ☐ No Is the requested medication prescribed by or in consultation with a hematologist?
☐ Yes ☐ No Is the patient eligible for hematopoietic stem cell transplant (HSCT) but is unable to find a human leukocyte antigen (HLA)-matched related donor?
☐ Yes ☐ No Has the patient received a prior hematopoietic stem cell transplant (HSCT)?
☐ Yes ☐ No Has the patient previously received the requested medication or any other gene therapy?

For Initiation Requests (clinical documentation required for all requests):

Sickle cell disease

☐ Yes ☐ No Has molecular or genetic testing been done to confirm the genotype?
☐ Yes ☐ No Does the patient have a βs/βs, βs/β0, or βs/β+ genotype confirmed by molecular or genetic testing?
☐ Yes ☐ No Does the patient have a documented history of at least 2 severe vaso-occlusive episodes (e.g., acute pain event requiring a visit to a medical facility and administration of pain medications (opioids or intravenous [IV] non-steroidal anti-inflammatory drugs [NSAIDs]) or RBC transfusions, acute chest syndrome, priapism lasting > 2 hours and requiring a visit to a medical facility, splenic sequestration, hepatic sequestration) per year during the previous two years?

Transfusion-dependent beta-thalassemia (TDT)

☐ Yes ☐ No Has molecular or genetic testing been done to confirm the genotype?
☐ Yes ☐ No Does the patient have non-beta-0/beta-0 OR beta-0/beta-0 genotype confirmed by molecular or genetic testing?
☐ Yes ☐ No Has the patient received at least 100 milliliter per kilogram or 10 units of packed red blood cells (pRBCs) per year during the previous two years?

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Patient First Name	Patient Last Name	Patient Phone	Patient DOB

G. CLINICAL INFORMATION *(continued)* – Required clinical information must be completed in its entirety for all precertification requests.

☐ Yes ☐ No Will the administration of the requested drug be provided at an Aetna designated gene therapy treatment center?

→ Please indicate the designated gene therapy treatment center: _____

H. ACKNOWLEDGEMENT

Request Completed By *(Signature Required):* _____ **Date:** ____/____/____

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

The plan may request additional information or clarification, if needed, to evaluate requests.