Zynteglo® (betibeglogene 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: Zynteglo (betibeglogene 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 Initiation of Therapy (clinical documentation required):

☐ Yes ☐ No Has the patient been diagnosed with transfusion-dependent beta-thalassemia?
☐ Yes ☐ No Has genetic testing been done to confirm the genotype?
→ ☐ Yes ☐ No Does the patient have a non-beta-0/beta-0 OR beta-0/beta-0 genotype confirmed via genetic testing?
☐ Yes ☐ No Does the patient require regular blood cell transfusions?
→ ☐ Yes ☐ No In the past two years, has the patient received at least 100 milliliter per kilogram of packed red blood cells (pRBCs) per year?
→ ☐ Yes ☐ No In the past two years, has the patient received at least 8 transfusions events of packed red blood cells (pRBCs) per year?
☐ Yes ☐ No Is the patient eligible for a hematopoietic stem cell transplant (HSCT) but is unable to find a 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?
☐ Yes ☐ No Is the patient reasonably anticipated to provide at least the minimum number of cells required to initiate the manufacturing process?
☐ Yes ☐ No Is the requested medication prescribed by or in consultation with a hematologist?

Please indicate which of the following conditions applies to the patient:
☐ Positive for the presence of human immunodeficiency virus type 1 or 2 (HIV-1 and HIV-2), hepatitis B virus (HBV), or hepatitis C (HCV)
☐ Any prior or current malignancy
☐ Advanced liver disease (e.g., bridging fibrosis, cirrhosis, active hepatitis)
☐ Severely elevated iron in the heart (i.e., patients with cardiac T2* less than 10 msec by MRI)
☐ None of the above

Continued on next page

Zynteglo® (betibeglogene 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

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.