HEALTHY U CHIP

PRIOR AUTHORIZATION REQUEST FORM
Zynteglo®

For authorization, please answer each question and fax this form PLUS chart notes back to the Healthy U CHIP Prior Authorization Department at 801-213-1547.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have medical pharmacy prior authorization questions, please call for assistance: 833-981-0212

Disclaimer: Prior authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Product being requested: ☐ Zynteglo® (betibeglogene autotemcel)

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section.

Questions	Yes	No	Comments/Notes
1. Is the request made by a board-certified hematologist and will be administered in a Qualified Treatment Center?	☐	☐	
2. Does the member have a diagnosis of non- β^0/β^0 genotype Beta thalassemia confirmed by hemoglobin electrophoresis or high-performance liquid chromatography (HPLC)?	☐	☐	**Please provide documentation**
3. Does clinical documentation show transfusion dependence including transfusions of at least 100 ml per kilogram of body weight of packed red cells per year in the 2 years before enrollment OR at least 8 transfusions per year in the 2 years before enrollment?	☐	☐	**Please provide documentation**
4. Is the member between the ages of 4 and 34 years?	☐	☐	
5. Does clinical documentation show haematopoietic stem cell transplantation (HSCT) is appropriate but a human leukocyte antigen (HLA)-matched related HSC donor is not available?	☐	☐	**Please provide documentation**
6. Does clinical documentation show an absence of active infections, including Hepatitis B, Hepatitis C, Human T-lymphotrophic virus (HTLV), and Human Immunodeficiency Virus (HIV) from within the past 3 months?	☐	☐	**Please provide documentation**
7. Does clinical documentation show WBC count ≥ 3 x 10^9/L and platelet count ≥ 100 x 10^9/L?	☐	☐	**Please provide documentation**
8. Does documentation show a negative pregnancy test if female?	☐	☐	**Please provide documentation**

REAUTHORIZATION Not applicable. Authorization is limited to a one-time authorization per lifetime
What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.
Additional information:
Physician Signature:

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Policy: PHARM-CHIP-M042
Origination Date: 07/01/2024
Reviewed/Revised Date:
Next Review Date:
Current Effective Date: 07/01/2024