Cigna Healthcare Casgevy Gene Therapy Prior Auth Transfusion-Dependent Beta-Thalassemia

This therapy requires supportive documentation (chart notes, genetic test results, etc.).

Gene Therapy Prior Authorization

To allow more efficient and accurate processing of your medication request, please complete this form and fax it back along with copies of all supporting clinical documentation. Fax completed form to Fax# 833-910-1625.

Notice: Failure to complete this form in its entirety may result in delayed processing or an adverse determination for insufficient information.

Gene Therapy Product Name: **Casgevy for Transfusion-Dependent Beta-Thalassemia**

Cigna has designated the above product to be a gene therapy product, which is included in the Cigna Gene Therapy Provider Network.

Questions pertaining to gene therapy may be directed to the dedicated Gene Therapy Program team at 855.678.0051 or email to GeneTherapyProgram@Cigna.com

<table>
<tr><th colspan="4">PHYSICIAN INFORMATION</th><th colspan="4">PATIENT INFORMATION</th></tr>
<tr><td colspan="4">*Physician Name:</td><td colspan="4" rowspan="2">Due to privacy regulations, we will not be able to respond via fax with the outcome of our review unless all asterisked (*) items on this form are completed.</td></tr>
<tr><td colspan="2">Specialty:</td><td colspan="2">*DEA, NPI or TIN:</td></tr>
<tr><td colspan="4">Office Contact Person:</td><td colspan="4">*Customer Name:</td></tr>
<tr><td colspan="4">Office Phone:</td><td colspan="2">*Cigna ID:</td><td colspan="2">*Customer Date of Birth:</td></tr>
<tr><td colspan="4">Office Fax:
*Is your fax machine kept in a secure location:
☐ Yes
☐ No

*May we fax our response to your office?
☐ Yes
☐ No</td><td colspan="4">*Customer / Patient Street Address:</td></tr>
<tr><td colspan="4">Office Street Address:</td><td>City:</td><td>State:</td><td colspan="2">Zip:</td></tr>
<tr><td>City:</td><td>State:</td><td colspan="2">Zip:</td><td colspan="4">Patient Phone:</td></tr>
<tr><td colspan="8">Urgency:
☐ Standard
☐ Urgent (in checking this box, I attest to the fact that applying the standard review time frame may seriously jeopardize the customer's life, health, or ability to regain maximum function)</td></tr>
<tr><td colspan="8">Where will this medication be obtained?
☐ Buy and Bill / Office Stock
☐ Other</td></tr>
</table>

Where will this medication be administered?
Facility Name:
Address: State:

Tax ID#:

What location will this medication be administered?
☐ Outpatient Hospital ☐ Inpatient Hospital ☐ MD Office / Clinic
☐ Home ☐ Other

ICD 10 Associated with the Indication of this request:

Casgevy is considered medically necessary to treat Transfusion-Dependent Beta-Thalassemia when the following criteria are met, check all that apply:

☐ Patient is ≥ 12 years of age; AND

☐ Patient has not received a gene therapy for beta-thalassemia in the past **[verification in claims history required]**; AND
Note: If no claim for Casgevy or Zynteglo (betibeglogene autotemcel intravenous infusion) is present (or if claims history is not available), the prescribing physician confirms that the patient has not previously received Casgevy or Zynteglo.

☐ According to the prescribing physician, a hematopoietic stem cell transplantation is appropriate for the patient; AND

☐ Patient meets **ONE** of the following (i or ii):
- ☐ i. Patient does not have a Human Leukocyte Antigen (HLA)-matched donor; OR
- ☐ ii. Patient has an HLA-matched donor, but the individual is not able or is not willing to donate; AND

☐ Patient has ONE of the following genotypes as confirmed by genetic testing (i or ii):
- ☐ i. Non-β^0/β^0 genotype **[documentation required]**; OR
  Note: Examples include β^0/β^+, β^E/β^0, and β^+/β^+.
- ☐ ii. β^0/β^0 genotypes **[documentation required]**; AND
  Note: Other examples include $\beta^0/\beta^{+(IVS\text{-}I\text{-}110)}$ and $\beta^{+(IVS\text{-}I\text{-}110)}/\beta^{+(IVS\text{-}I\text{-}110)}$.

☐ Patient is transfusion-dependent, as defined by meeting ONE of the following (i or ii):
- ☐ i. Receipt of transfusions of ≥ 100 mL per kg of body weight of packed red blood cells per year in the previous 2 years **[documentation required]**; OR
- ☐ ii. Receipt of transfusions of ≥ 10 units of packed red blood cells per year in the previous 2 years **[documentation required]**; AND

☐ Patient meets BOTH of the following (i and ii):
- ☐ i. Patient has been evaluated for the presence of severe iron overload **[documentation required]**; AND
- ☐ ii. Patient does not have evidence of severe iron overload; AND
  Note: Examples include abnormal myocardial iron results (a T2-weighted magnetic resonance imaging measurement of myocardial iron of less than 10 msec); high liver iron concentration (≥ 15 mg/g); liver biopsy results suggest abnormalities; or clinical evidence of organ damage (e.g., endocrine comorbidities).*

☐ Patient does not currently have an active bacterial, viral, fungal, or parasitic infection; AND

☐ Patient does not have the following (i and ii):
- ☐ i. Prior or current malignancy, myeloproliferative disorder, or significant immunodeficiency disorder; AND
  Note: This does not include adequately treated cone biopsied in situ carcinoma of the cervix uteri and basal or squamous cell carcinoma of the skin.
- ☐ ii. Advanced liver disease **[documentation required]**; AND
  Note: Examples include alanine transaminase or aspartate transaminase greater than three times upper limit of normal, direct bilirubin value greater than three times upper limit of normal, active hepatitis, extensive bridging fibrosis, or cirrhosis.

☐ According to the prescribing physician, patient will have been discontinued from iron chelation therapy for at least 7 days prior to myeloablative conditioning; AND
Note: Examples of iron chelators used for this condition include deferoxamine injection, deferiprone tablets or solution, and deferasirox tablets.

☐ According to the prescribing physician, patient meets **ALL** the following (i, ii, iii, and iv):
- ☐ i. Patient will undergo mobilization, apheresis, and myeloablative conditioning; AND
- ☐ ii. A granulocyte-colony stimulating factor product and a hematopoietic stem cell mobilizer will be utilized for mobilization; AND
  Note: Filgrastim products are examples of a granulocyte-colony stimulating factor therapy and Mozobil (plerixafor subcutaneous injection) is an example of a hematopoietic stem cell mobilizer.
- ☐ iii. Busulfan will be used for myeloablative conditioning; AND
- ☐ iv. Total hemoglobin level is ≥ 11 g/dL at BOTH of the following timepoints (a **and** b):
  - ☐ a) Prior to mobilization; AND
  - ☐ b) Prior to myeloablative conditioning; AND

☐ Prior to collection of cells for manufacturing, cellular screening is negative for ALL of the following (i, ii, iii, and iv):
- ☐ i. Human immunodeficiency virus-1 and -2 **[documentation required]**; AND
- ☐ ii. Hepatitis B virus **[documentation required]**; AND
- ☐ iii. Hepatitis C virus **[documentation required]**; AND
- ☐ iv. Human T-lymphotropic virus-1 and -2 **[documentation required]**; AND

☐ According to the prescribing physician, patient meets ONE of the following (i or ii):
- ☐ i. A female† of reproductive potential meets BOTH of the following (a and b):
  - ☐ a) A negative serum pregnancy test will be confirmed prior to the start of each mobilization cycle and re-confirmed prior to myeloablative conditioning; AND
  - ☐ b) Patient will use an effective method of contraception from the start of mobilization through at least 6 months after administration of Casgevy; OR
- ☐ ii. A male† of reproductive potential will use an effective method of contraception from the start of mobilization through at least 6 months after administration of Casgevy; AND

☐ The medication is prescribed by a hematologist or a stem cell transplant physician; AND

☐ Current patient body weight has been obtained within 30 days **[documentation required]**;

If any of the requirements listed above are not met and the provider feels administration of Casgevy is medically necessary, please provide clinical support and rationale for the use of Casgevy.

Additional pertinent information: (including recent history and physical, recent lab work, disease stage, prior therapy, performance status, and names/doses/admin schedule of any agents to be used concurrently)

Any other use is considered experimental, investigational, or unproven, including the following, check all that apply:

☐ Prior Receipt of Gene Therapy. Prior receipt of gene therapy was a reason for patient exclusion in the pivotal study.

If any of above apply to your customer, please provide clinical support and rationale for the use of Casgevy.

Additional CPT and Administration Codes for Consideration Following Medical Necessity Determination

Cell Collection
☐ 96372 Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular
☐ 38206 Blood-derived hematopoietic progenitor cell harvesting for transplantation, per collection; autologous
☐ Other

Select applicable G-CSF (Cigna preferencing may apply). Include dose, quantity, duration
☐ J2562 Injection, plerixafor, 1mg (Mozobil) Plus
☐ J1442 Injection, filgrastim (G-CSF), excludes biosimilar, 1 mcg
☐ J1447 Injection, tbo-filgrastim, 1 mcg
☐ Q5101 Injection, filgrastim-sndz, biosimilar (Zarxio), 1 mcg
☐ Q5110 Injection, filgrastim-aafi, biosimilar (Nivestym), 1 mcg
☐ Other

Conditioning Regimen
☐ J0594 Injection, bulsulfan, 1 mg
☐ Other

Please indicate any other CPT codes that will be billed for administration.
☐ Other

Additional Attestation required for Embarc Benefit Protection*:
The prescribing physician confirms that the patient has not previously received Casgevy?
☐ Yes
☐ No
☐ Unknown

**For additional information on Embarc Benefit Protection refer to the Cigna Reference Guide of physicians, physicians, hospitals, ancillaries, and other health care providers. This guide is available at CignaforHCP.com > Resources > Reference Guides > Medical Reference Guides: View Documents > Health Care Professional Reference Guides. Providers must log in to access.*

Agreement and Attestation

Do you and your patient agree to share any required plan specific outcome measures?
☐ Yes
☐ No

I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan or insurer its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature: _____

Date: _____

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