Reset Form Print Form

Government of District of Columbia Department of Health Care Finance

Prior Authorization Form Casgevy (exagamglogene autotemcel)

Initial Prior Authorization Request

Request Date: _____

RECIPIENT INFORMATION

Recipient Medicaid ID: _____

Date of Birth: _____

Recipient Last Name: _____

Recipient First Name: _____ Middle Initial: _____

PRESCRIBER INFORMATION

Prescriber Last Name: _____

Prescriber First Name: _____

Prescriber Phone: _____

Prescriber Fax: _____

Prescriber DEA Number: _____

Prescriber NPI Number: _____

Prescriber Specialty: _____

PHARMACY INFORMATION

Pharmacy Name: _____

Pharmacy Phone: _____

Pharmacy Fax: _____

Pharmacy NPI Number: _____

Refer to FDA www.fda.gov for prescribing details and approved indications.

INFORMATION REQUIRED FOR PRIOR AUTHORIZATION APPROVAL

Sickle Cell Disease:

1. Recipient is 12 years of age or older on the date of the request.
   ☐ Yes ☐ No
2. The recipient has a diagnosis of sickle cell disease (SCD) confirmed by genetic testing.
   ☐ Yes ☐ No

SUBMIT TO Comagine Health DHCF DC Medicaid:
https://comagine.org/program/dc-medicaid-um

Revision Date: 04/24/2026

Recipient's Name (Last, First): _____

3. The provider states on the request that the recipient has experienced recurrent vaso-occlusive crisis (VOCs) events (defined as more than or equal to two severe VOCs per year for the previous two years) Or currently receiving chronic transfusion therapy for recurrent VOCs.
   ☐ Yes ☐ No
4. The recipient has had treatment failure, or intolerance to hydroxyurea (per health care professional judgement) at any point in the past.
   ☐ Yes ☐ No
5. This medication is prescribed by, or in consultation with, a board-certified hematologist with SCD experience.
   ☐ Yes ☐ No
6. The following are true and stated on the request:
   - The recipient is clinically stable and fit for hematopoietic stem cell (HSC) transplantation; **AND**
   - The recipient is eligible to receive HSC transplantation; **AND**
   - The recipient has not received prior HSC transplantation.

   ☐ Yes ☐ No

OR

Transfusion-Dependent Beta-Thalassemia

1. The recipient has a diagnosis of homozygous β-thalassemia or compound heterozygous βthalassemia including β-thalassemia/hemoglobin E (HbE).
   ☐ Yes ☐ No
2. The provider states on the request that the recipient is transfusion-dependent defined by a history of **one** of the following in the 2-year period prior to the request:
   - At least 10 units/year of packed red blood cells (pRBCs); **OR**

   ☐ Yes ☐ No
   - At least 100 mL/kg/year of pRBCs

   ☐ Yes ☐ No

Complete this section for all recipients.

1. This medication is prescribed by a hematologist.
   ☐ Yes ☐ No
2. The recipient has had a treatment failure with at least one preferred product.
   ☐ Yes ☐ No

   OR

Recipient's Name (Last, First): _____

3. If the request is for a non-preferred agent, **one** of the following is required:
   - The recipient has had a treatment failure with at least one preferred product; **OR**
   - The recipient has had an intolerable side effect to at least one preferred product; **OR**
   - The recipient has a documented contraindication(s) to all of the preferred products that are appropriate to use for the condition being treated; **OR**
   - There is no preferred product that is appropriate to use for the condition being treated.

   ☐ Yes ☐ No

   AND

The following are true and stated on the request:

- The recipient has not tested positive for human immunodeficiency virus (HIV) infection, hepatitis B virus (HBV) or hepatitis C virus (HCV); ****Alternative CASGEVY should not be used in recipients with active HIV-1, HIV-2, HBV or HCV; AND**
- The recipient is not pregnant or breastfeeding **AND**
- The recipient is eligible to receive hematopoietic stem cell (HSC) transplantation; **AND**
- The recipient has not received prior HSC transplantation; **AND**
- The recipient does not have a clinically significant and active bacterial, viral, fungal, or parasitic infection.

Duration of approval: 12 months – allow 1 dose per lifetime for both indications

---

By submitting the authorization request, the prescriber attests to the following:

- The prescribing information for the requested medication has been thoroughly reviewed, including any Black Box Warning, Risk Evaluation and Mitigation Strategy (REMS), contraindications, minimum age requirements, recommended dosing, and prior treatment requirements; **AND**
- All laboratory testing and clinical monitoring recommended in the prescribing information have been completed as of the date of the request and will be repeated as recommended; **AND**
- The recipient has no concomitant drug therapies or disease states that limit the use of the requested medication and will not be receiving the requested medication in combination with any other medication that is contraindicated or not recommended per FDA labeling.

Attestation: I certify that the information provided is accurate and complete to the best of my knowledge, and I understand the Health Plan, insurer, or its designees may request additional medical information necessary to verify the accuracy of information reported, and that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Prescriber's Signature: _____ **Date:** _____

Submit to Comagine Health DHCF DC Medicaid**:** https://comagine.org/program/dc-medicaid-um.