CASGEVY (exagamglogene autotemcel) PRIOR AUTHORIZATION FORM *(form effective 1/5/2026)*

FAX this completed form to (844) 205-3386
OR Mail requests to: Pharmacy Department | 5 River Park Place East, Suite 210 | Fresno, CA 93720
OR Prior authorization may be completed at https://www.covermymeds.com/main/prior-authorization-forms/

Prior authorization guidelines for **Casgevy (exagamglogene autotemcel)** are available on the PA Health & Wellness website at https://www.pahealthwellness.com/providers/pharmacy.html.

Member name:	Member ID#:	Member DOB:
Prescriber name:		Prescriber NPI:
Prescriber address (street/city/state/zip):		
Prescriber specialty:	Prescriber phone:	Prescriber fax:
Office contact name:	Office contact phone:	Office contact fax:
Service provider name:		Service provider MA ID:
Service provider address (street/city/state/zip):		

Drug name: **Casgevy**	Member's weight (kg):	Dose: _____ x 10^6 CD34+ cells/kg
Place of service:		Anticipated date of infusion:
Diagnosis *(submit documentation)*:	Dx code (*required*):	HCPCS code *(required)*:

Complete the sections below that apply to the member and this request.
Check all that apply and submit documentation (e.g., recent chart notes, diagnostic evaluations, test results, etc.) for each item.

1. **For ALL DIAGNOSES:**
   - ☐ Is clinically stable for transplantation based on the prescriber's assessment.
2. **For the treatment of SICKLE CELL DISEASE:**
   - ☐ Has sickle cell disease with confirmatory genetic testing.
   - ☐ At least one of the following:
     - ☐ Has a history of vaso-occlusive episodes (e.g., pain crises, acute chest syndrome, splenic sequestration, priapism) that required a medical facility visit (e.g., emergency department, hospital).
     - ☐ Is currently receiving chronic transfusion therapy for recurrent vaso-occlusive episodes.
3. **For the treatment of TRANSFUSION-DEPENDENT β-THALASSEMIA:**
   - ☐ Has genetic testing confirming the diagnosis of β-thalassemia.
   - ☐ Has a history of at least 100 mL/kg/year or 8 transfusion episodes/year of packed red blood cell transfusions in the prior 2 years.

PLEASE FAX COMPLETED FORM WITH SUPPORTING CLINICAL DOCUMENTATION TO 844-205-3386

Prescriber Signature:	**Date**: