pa health & wellness

LYFGENIA (lovotibeglogene 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 **Lyfgenia (lovotibeglogene 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: **Lyfgenia**	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)*:

Check all that apply and submit documentation (e.g., recent chart/clinic notes, diagnostic evaluations, test results, etc.) for each item.

- ☐ Is clinically stable for transplantation based on the prescriber's assessment.
- ☐ Has NOT received a prior allogeneic hematopoietic stem cell transplant.
- ☐ 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.

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

Prescriber Signature:	**Date**: