Clinical Criteria Worksheet:
Hemgenix® (etranacogene dezaparvovec-drlb)

Enrollee Information

Enrollee Last Name:

Enrollee First Name:

Date of Birth (MM/DD/YYYY):

/ /

Enrollee Medicaid ID (2 letters, 5 numbers, 1 letter):

Address:

City, Town or Post Office:

State:

ZIP Code:

Prescriber Information

Prescriber Last Name:

Prescriber First Name:

National Provider Identifier (NPI) Number:

Preferred Contact (Telephone Number)

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Enrollee Last Name: | | | | | | | | | | | | |

Enrollee First Name: | | | | | | | | | | | | |

Drug Information

Drug Administration:

Provide the date of drug administration (MM/DD/YYYY):

☐☐ / ☐☐ / ☐☐☐☐

Provide the expiration date of the drug if the invoice date is greater than six (6) months from the date of drug administration (MM/DD/YYYY):

☐☐ / ☐☐ / ☐☐☐☐

Clinical Criteria

1. Does the patient have a congenital hemophilia B?

   ☐ Yes ☐ No

2. Does the patient have moderately severe or severe hemophilia B?

   ☐ Yes ☐ No

3. Does the patient have a history of Factor IX inhibitors?

   ☐ Yes ☐ No

4. Did the patient have a positive Factor IX inhibitor test?

   ☐ Yes ☐ No

5. Has the patient received any previous treatment with Hemgenix®?
   (Hemgenix® treatment is limited to one treatment per patient for their lifetime.)

   ☐ Yes ☐ No

Enrollee Last Name:

Enrollee First Name:

Attestation

I attest that this is medically necessary for this patient and that all of the information on this form is accurate to the best of my knowledge. I attest that documentation of the above diagnosis and medical necessity is available for review if requested by the New York State Medicaid Program.

Prescriber Signature (Required)

Date (MM/DD/YYYY)