Clinical Criteria Worksheet:
Zynteglo® (betibeglogene autotemcel)

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)

– –

Pharmacy Information (if dispensed by a pharmacy)

Pharmacy Name:

Phone number:

– –

National Provider Identifier (NPI) Number:

Enrollee Last Name:

Enrollee First Name:

Drug Information

Drug Administration:

Provide the date or expected 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 the drug was administered (MM/DD/YYYY):

/ /

Clinical Criteria

1. Does the patient have a diagnosis of transfusion-dependent beta-thalassemia?

   Transfusion-depended beta-thalassemia is defined as a history of at least 100 mL/kg/year of packed red blood cells (pRBC) in the two (2) years preceding administration of betibeglogene autotemcel or with greater than or equal to eigh (8) transfusions of pRBCs per year in the two (2) years preceding administration of betibeglogene autotemcel.

   ☐ Yes ☐ No

2. Is the patient a candidate to undergo allogeneic hematopoietic cell transplantation, but ineligible due to the absence of a suitable donor?

   ☐ Yes ☐ No

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

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

3. Is the patient less than or equal to fifty (50) years of age?

☐ Yes ☐ No

4. Is the patient less than five (5) years of age?

☐ Yes ☐ No

If Yes, does the patient weigh greater than or equal to six (6) kilograms?

☐ Yes ☐ No

(Zynteglo® is not covered for patients less than four [4] years of age regardless of weight)

5. Is the patient on any anti-retroviral medications?

☐ Yes ☐ No

6. Has the patient received any previous treatment with Zynteglo®?

(Zynteglo® 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)