# Skysona® (elivaldogene autotemcel) Medication Precertification Request



(All fields must be completed and legible for precertification review.)

**Aetna Precertification Notification**
**Phone:** 1-866-752-7021
**FAX:** 1-888-267-3277

**For Medicare Advantage Part B:**
Please Use Medicare Request Form

**Please indicate:** ☐ Start of treatment: Start date ____/____/____
☐ Continuation of therapy, Date of last treatment ____/____/____

**Precertification Requested By:** ______________________ Phone: __________ Fax: __________

## A. PATIENT INFORMATION

| First Name: | | Last Name: | DOB: | |
|---|---|---|---|---|
| Address: | | City: | State: | ZIP: |
| Home Phone: | Work Phone: | Cell Phone: | Email: | |

Patient Current Weight: _____ lbs or _____ kgs Patient Height: _____ inches or _____ cms | Allergies:

## B. INSURANCE INFORMATION

**Aetna Member ID #**: ______________________
**Group #**: ______________________
**Insured**:

Does patient have other coverage? ☐ Yes ☐ No
If yes, provide ID#: ______________ Carrier Name: ______________
Insured:

**Medicare:** ☐ Yes ☐ No If yes, provide ID #: **Medicaid:** ☐ Yes ☐ No If yes, provide ID #:

## C. PRESCRIBER INFORMATION

| First Name: | | Last Name: *(Check One)*: ☐ M.D. ☐ D.O. ☐ N.P. ☐ P.A. | | | |
|---|---|---|---|---|---|
| Address: | | City: | | State: | ZIP: |
| Phone: | Fax: | St Lic #: | NPI #: | DEA #: | UPIN: |
| Provider Email: | | Office Contact Name: | | Phone: | |

**Specialty** *(Check one)*: ☐ **Neurologist** ☐ **Endocrinologist** ☐ **Other**: ______________________

## D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

**Place of Administration:**
☐ Self-administered ☐ Physician's Office
☐ Outpatient Infusion Center Phone: ______________
Center Name: ______________
☐ Home Infusion Center Phone: ______________
Agency Name: ______________
☐ Administration code(s) (CPT): ______________
Address: ______________

**Dispensing Provider/Pharmacy:** *Patient Selected choice*
☐ Physician's Office ☐ Retail Pharmacy
☐ Specialty Pharmacy ☐ Other
Name: ______________
Address: ______________
Phone: ______________ Fax: ______________
**TIN:** ______________ PIN: ______________

## E. PRODUCT INFORMATION

**Request is for: Skysona (elivaldogene autotemcel) Dose:** ______________ **Frequency:** ______________

## F. DIAGNOSIS INFORMATION - Please indicate primary ICD code and specify any other where applicable.

**Primary ICD Code:** ☐ ______________ **Secondary ICD Code :** ______________ **Other ICD Code:** ______________

## G. CLINICAL INFORMATION - Required clinical information must be completed in its entirety for all precertification requests.

**For ALL Requests (clinical documentation required):**

☐ Yes ☐ No Does the patient have a diagnosis of cerebral adrenoleukodystrophy (CALD)?
☐ Yes ☐ No Is the patient male?
☐ Yes ☐ No Will the requested medication be prescribed by or in consultation with a prescriber who specializes in the treatment of adrenoleukodystrophy (ALD)?
☐ Yes ☐ No Will the requested drug be used to treat or prevent adrenal insufficiency?
☐ Yes ☐ No Does the patient have cerebral adrenoleukodystrophy (CALD) secondary to head trauma?
☐ Yes ☐ No Does the patient have full deletions of ABCD1 transgene as detected by genetic testing?
☐ Yes ☐ No Does the patient have a variant in the ABCD1 gene as detected by genetic testing?
☐ Yes ☐ No Does the patient have elevated very long chain fatty acids (VLCFA) values per reference range of the laboratory performing the test?
☐ Yes ☐ No Has the patient had a central radiographic review of brain magnetic resonance imaging (MRI) demonstrating early active central nervous (CNS) disease?
→ ☐ Yes ☐ No Does the MRI demonstrate a Loes score between 0.5 and 9 (inclusive) on the 34-point scale?
☐ Yes ☐ No Does the MRI demonstrate gadolinium enhancement of demyelinating lesions?
☐ Yes ☐ No Does the patient have a Neurologic Function Score (NFS) of less than or equal to 1?
☐ Yes ☐ No Is the patient eligible for hematopoietic stem cell transplant (HSCT) but is unable to find a matched sibling donor?
☐ Yes ☐ No Has the patient previously received the requested drug or any other gene therapy?
☐ Yes ☐ No Has the patient received a prior allogeneic hematopoietic stem cell transplant (allo-HSCT)?

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| Patient First Name | Patient Last Name | Patient Phone | Patient DOB |
|---|---|---|---|
| | | | |

## H. ACKNOWLEDGEMENT

**Request Completed By *(Signature Required)*:** ______________________________ **Date:** ____/____/____

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

The plan may request additional information or clarification, if needed, to evaluate requests.