



Zynteglo® (betibeglogene autotemcel) Medication Precertification Request

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(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 #: _____		Does patient have other coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Group #: _____		If yes, provide ID#: _____ Carrier Name: _____	
Insured: _____		Insured: _____	
Medicare: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide ID #: _____		Medicaid: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide ID #: _____	

C. PRESCRIBER INFORMATION

First Name:		Last Name:		(Check One): <input type="checkbox"/> M.D. <input type="checkbox"/> D.O. <input type="checkbox"/> N.P. <input type="checkbox"/> P.A.	
Address:			City:		State: ZIP:
Phone:		Fax:		St Lic #: NPI #: DEA #: UPIN:	
Provider Email:			Office Contact Name:		Phone:

Specialty (Check one): Hematologist Other: _____

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration:		Dispensing Provider/Pharmacy: Patient Selected choice	
<input type="checkbox"/> Self-administered <input type="checkbox"/> Physician's Office <input type="checkbox"/> Outpatient Infusion Center Phone: _____ Center Name: _____ <input type="checkbox"/> Home Infusion Center Phone: _____ Agency Name: _____ <input type="checkbox"/> Administration code(s) (CPT): _____ Address: _____		<input type="checkbox"/> Physician's Office <input type="checkbox"/> Retail Pharmacy <input type="checkbox"/> Specialty Pharmacy <input type="checkbox"/> Other Name: _____ Address: _____ Phone: _____ Fax: _____ TIN: _____ PIN: _____	

E. PRODUCT INFORMATION

Request is for: Zynteglo (betibeglogene 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 Initiation of Therapy (clinical documentation required):

Yes No Has the patient been diagnosed with transfusion-dependent beta-thalassemia?

Yes No Has genetic testing been done to confirm the genotype?
↳ Yes No Does the patient have a non-beta-0/beta-0 OR beta-0/beta-0 genotype confirmed via genetic testing?

Yes No Does the patient require regular blood cell transfusions?
↳ Yes No In the past two years, has the patient received at least 100 milliliter per kilogram of packed red blood cells (pRBCs) per year?
↳ Yes No In the past two years, has the patient received at least 8 transfusions events of packed red blood cells (pRBCs) per year?

Yes No Is the patient eligible for a hematopoietic stem cell transplant (HSCT) but is unable to find a matched related donor?

Yes No Has the patient received a prior hematopoietic stem cell transplant (HSCT)?

Yes No Has the patient previously received the requested medication or any other gene therapy?

Yes No Is the patient reasonably anticipated to provide at least the minimum number of cells required to initiate the manufacturing process?

Yes No Is the requested medication prescribed by or in consultation with a hematologist?

Please indicate which of the following conditions applies to the patient:

Positive for the presence of human immunodeficiency virus type 1 or 2 (HIV-1 and HIV-2), hepatitis B virus (HBV), or hepatitis C (HCV)

Any prior or current malignancy

Advanced liver disease (e.g., bridging fibrosis, cirrhosis, active hepatitis)

Severely elevated iron in the heart (i.e., patients with cardiac T2* less than 10 msec by MRI)

None of the above

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Patient First Name	Patient Last Name	Patient Phone	Patient DOB
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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.