ambetter. FROM peach state health plan

Telephone: (800) 514-0083 option 2
Fax: (866) 374-1579

Betibeglogene Autotemcel (Zynteglo)
PDAC Drug Review Form

The information below can be completed by the Health Plan and/or Centene Pharmacy Services (CPS) staff

Patient Information

*Last Name:	*First Name:	Middle:	*DOB: / /
Daytime Phone:	Evening Phone:	*Sex: ☐ Male ☐ Female	

Insurance Information

*Primary Insurance (Health Plan Name and State)	*ID #:

Physician Information

*Name:	*Specialty:	*Phone #:

Procedural Hospital

*Hospital Name:

Primary Diagnosis

*ICD-10 Code: _____

☐β-thalassemia ☐Other: _____

Prescription Information

MEDICATION	STRENGTH	*DIRECTIONS	QUANTITY	REFILLS
Zynteglo (Betibeglogene Autotemcel)				

Clinical Information

***** *Please submit supporting clinical documentation* *****

* **THERAPY Start Date**: _____

1. Is therapy prescribed by or in consultation with a hematologist and transplant specialist? ☐Yes ☐No
2. Is β-thalassemia with genetic confirmation (β-thalassemia genotype)? ☐Yes ***Mark all that apply*** ☐No
   ☐β^0/β^0 ☐β^0/β^+ ☐β^+/β^+ ☐β^E/β^0 ☐β^+ IVS1-110/β^+ IVS1-110 ☐β^0/β+ IVS1-110 ☐Other: _____
3. Please provide patient's weight: _____ kg
4. Is there documentation of 1 of the following per year in the 2 previous years? ☐Yes ***Mark all that apply*** ☐No
   ☐Receipt of ≥ 8 transfusions of packed red blood cells (pRBC*) ☐Receipt of ≥ 100 mL/kg pRBC*
   **1 RBC unit refers to a quantity of pRBC approximately 200-350 mL*
5. Is there attestation from transplant specialist for both of the following? ☐Yes ***Mark all that apply*** ☐No
   ☐Patient is clinically stable and eligible to undergo myeloablative conditioning and HSCT
   ☐Patient understands the risks and benefits of alternative therapeutic options such as allogenic hematopoietic stem cell transplantation (HSCT)
6. Has patient previously received allogenic HSCT or gene therapy? ☐Yes, both ☐Yes, HSCT ☐Yes, gene therapy ☐No
7. Does patient have advanced liver disease? ☐Yes ***Mark all that apply*** ☐No
   ☐Cirrhosis ☐Active hepatitis ☐Bridging fibrosis ☐Fatty liver disease ☐Other: _____
8. Is there documentation within the last 6 months that the patient is negative for the presence HIV type 1 or 2? ☐Yes ☐No
9. Does patient have any prior or current malignancy? ☐Yes ☐No
10. How many Zynteglo infusions has patient receive in their lifetime? ☐0 ☐1 or more

Complete this section ONLY for indications <u>other</u> than β-thalassemia:

11. Has patient tried and failed, or is contraindicated to, accepted standards of care? ☐Yes ☐No

    ****If yes, submit documentation and answer the following:*****

    a. Please list all previous therapies: _____
    b. Was patient adherent to previously tried therapies? ☐Yes ☐No ☐No, patient intolerant to drug

Information

*Number:	*Date of Request:

PDAC updated: 09/08/2025
AMB25-GA-HP-00216

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*HCPCS Code:	*Decision Due Date:

Please continue to page 2.

Patient Name: _____ DOB: _____

* Line of Business:	* Benefit:
☐ Commercial ☐ Health Insurance Marketplace ☐ Medicaid ☐ Medicare	☐ Medical ☐ Pharmacy

*** Choose one criteria option below based on line of business:**

Medicare Criteria Only:

☐ Medicare Local Coverage Decision (LCD) specific for your region
Please include policy of link to LCD, followed by any applicable Medicare Part B step therapy requirements in MCPB.ST.00.

☐ Medicare National Coverage Decision (NCD).
Please include policy of link to NCD, followed by any applicable Medicare Part B step therapy requirements in MCPB.ST.00.

Medicaid, Commercial, Exchange (Ambetter) Criteria:

☐ Centene Policy [**CP.PHAR.545 Betibeglogene autotemcel (Zynteglo)]**
Date Policy last reviewed/approved by plan (we want to be sure we are using the version approved by your plan):

_____

OR

☐ State or Health Plan Specific (please include policy)