ambetter. FROM peach state health plan

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

Etranacogene dezaparvovec-drlb (Hemgenix)
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:

☐ Congenital hemophilia B (factor IX deficiency) ☐ Other: _____

Prescription Information

MEDICATION	STRENGTH	*DIRECTIONS	QUANTITY	REFILLS
Hemgenix (etranacogene dezaparvovec-drlb)				

Clinical Information

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

* **THERAPY Start Date**: _____

1. Is Hemgenix prescribed by or in consultation with a hematologist? ☐Yes ☐No
2. Has patient had severe or moderately severe hemophilia? ☐Yes ☐No
3. Please provide the following patient information:
   a) Weight: _____ kg
   b) Factor IX level: _____ %
   c) Inhibitor level assay: _____ Bethesda units (BU), date: _____
   d) Adeno-associated virus serotype 5 (AAV5) neutralizing antibody titer: _____ : _____
4. Has patient been adherent to current use of a factor IX product for routine prophylaxis as assessed and documented by prescriber? ☐Yes **Mark all that apply** ☐No
   ☐Alprolix ☐Benefix ☐Idelvion ☐Ixinity ☐Rebinyn ☐Rixubis ☐Other: _____
5. Does patient have current or historical life-threatening hemorrhage? ☐Yes ☐No
6. Has patient been treated with factor IX product for a minimum of 150 exposure days (ED)*?
   ☐Yes **Mark all that apply** ☐No
   **ED defined days on which factor was infused with factor concentrate to treat or prevent a bleed on a person with hemophilia.*
7. Does patient have repeated serious spontaneous bleeding episodes?
   ☐Yes **Mark all that apply** ☐No
   ☐Intracranial ☐Neck/throat ☐Gastrointestinal ☐Joints (hemarthrosis) ☐Muscles (e.g., iliopsoas, calf, forearm)
   ☐Mucous membranes of the mouth, nose & genitourinary tract ☐Other: _____
8. Is there documented history of a detectable factor IX inhibitor? ☐Yes ☐No
9. Has patient had initial factor IX inhibitor positive test? ☐Yes ☐No
   a) *If* yes, is there documentation of subsequent negative test within 2 weeks?
      ☐Yes, positive test date: _____ and negative test date: _____ ☐No
10. Has patient had both of the following documented baseline liver assessments within the last 3 months?
    ☐Yes **Mark all that apply** ☐No
    ☐Normal hepatic ultrasound and elastography
    ☐Liver enzymes within normal limits (e.g., alanine aminotransferase, aspartate aminotransferase, alkaline phosphatase & total bilirubin)

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

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

Etranacogene dezaparvovec-drlb (Hemgenix)
PDAC Drug Review Form

11. Has patient had evidence of radiological liver abnormalities and/or sustained liver enzyme elevations? ☐Yes ☐No
    a) *If yes*, does hepatologist attest that patient is eligible for Hemgenix? ☐Yes ☐No
12. Has patient received prior gene therapy? ☐Yes ☐No
13. Has the patient been tested for neutralizing anti-adeno-associated virus serotype 5 (AAV5) antibodies and been deemed a suitable candidate for treatment? ☐Yes ☐No
14. How many Hemgenix infusions has patient received? ☐0 ☐1 ☐≥1

Please continue to page 2.

Patient Name: _____ **DOB:** _____

Complete this section ONLY for indications other than congenital hemophilia B:

15. 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:**
***HCPCS Code:**	***Decision Due Date:**
* **Line of Business:** ☐ Commercial ☐ Health Insurance Marketplace ☐ Medicaid ☐ Medicare	* **Benefit:** ☐ 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.580 Etranacogene Dezaparvovec-drlb (Hemgenix)]**
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)