ambetter. FROM peach state health plan

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

Fidanacogene Elaparvovec-dzkt (Beqvez)
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
Beqvez (Fidanacogene Elaparvovec-dzkt)				

Clinical Information

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

* **THERAPY Start Date**: _____

1. Is therapy prescribed by or in consultation with a hematologist? ☐Yes ☐No
2. Please provide patient's weight: _____ kg
3. Does patient have severe or moderately severe hemophilia? ☐Yes, factor IX level _____ % ☐No
4. Is there documentation that patient has been adherent with 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 50 exposure days? ☐Yes ***Mark all that apply**** ☐No
   ☐Alprolix ☐Benefix ☐Idelvion ☐Ixinity ☐Rebinyn ☐Rixubis ☐Other: _____
7. Has there been repeated serious spontaneous bleeding episodes?
   ☐Yes ***Mark all that apply**** ☐No
   ☐Intracranial ☐Neck/throat ☐Gastrointestinal ☐Joints (hemarthrosis)
   ☐Muscles (deep compartments such as the iliopsoas, calf, forearm)
   ☐Mucous membranes of the mouth, nose, and genitourinary tract ☐Other: _____
8. Is there documented history of a detectable factor IX inhibitor? ☐Yes ☐No
9. Is there documentation of inhibitor level assay < 0.6 Bethesda units (BU) within the last 12 months?
   ☐Yes, _____ BU, date: _____ ☐No
10. Is there documentation of a positive or negative test for HIV-1 and HIV-2 infection? ☐Yes, positive ☐Yes, negative ☐No
    a. *If positive*, is there documentation of a CD4+ cell count ≥ 200/mm³ or a viral load ≤ 20 copies/mL?
    ☐Yes, _____ /mm³ or _____ copies/mL ☐No
11. Has patient had all of the following baseline liver assessments within the last 3 months?
    ☐Yes ***Mark all that apply**** ☐No
    ☐Documentation of liver function tests within normal limits (e.g., ALT, AST, ALP, bilirubin, albumin) date: _____
    ☐Documentation of normal hepatic ultrasound and elastography date: _____
    ☐Documentation of negative laboratory tests for active hepatitis B and hepatitis C date: _____
    ☐Evidence of radiological liver abnormalities and/or sustained liver enzymes elevations date: _____
    a. At the time of request, does patient have any of the following? ☐Yes ***Mark all that apply**** ☐No
    ☐Liver-related coagulopathy ☐Hypoalbuminemia ☐Persistent jaundice ☐Cirrhosis ☐Active viral hepatitis

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☐Hepatic encephalopathy ☐Splenomegaly ☐Portal hypertension ☐Hepatic fibrosis

12. Does hematologist attest patient is eligible for Beqvez? ☐Yes ☐No
13. Has patient received prior gene therapy? ☐Yes ☐No
14. Is there documentation of negative test for antibodies to AAVRh74var? ☐Yes ☐No
15. How many Beqvez infusions has patient received? ☐Yes ☐No

Please continue to page 2.

Patient Name: _____ **DOB:** _____

Complete this section ONLY for indications other than Congenital Hemophilia B (factor IX deficiency):

16. 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.643 Fidanacogene Elaparvovec-dzkt (Beqvez)**]
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)