CASGEVY
(exagamglogene autotemcel)
PRIOR AUTHORIZATION FORM

(form effective 1/5/2026)

Keystone First | PerformRx[SM] Next Generation Pharmacy Benefits

Fax to PerformRx[SM] at **1-866-497-1387**, or to speak to a representative call **1-800-588-6767**.

BENEFICIARY INFORMATION		
Beneficiary name:	Beneficiary ID#:	DOB:

PRESCRIBER INFORMATION	
Prescriber name:	
Specialty:	NPI:
Prescriber address (street/city/state/zip):	
Prescriber phone:	Prescriber fax:

OFFICE CONTACT INFORMATION	
Office contact name:	
Office contact phone:	Office contact fax:

BILLING PROVIDER INFORMATION	
Billing provider name:	Billing provider NPI:
Billing provider address:	

CLINICAL INFORMATION		
Drug name: Casgevy	Beneficiary's weight (kg):	Dose:________________ x 10^6 CD34+ cells/kg
Place of service:		Anticipated date of infusion:
Diagnosis *(submit documentation)*:		Dx code *(required)*:

INITIAL REQUESTS

Complete all sections that apply to the beneficiary and this request.
Check all that apply and *submit documentation* (e.g., recent chart/clinic notes, diagnostic evaluations, test results) for each item.

1. **For ALL DIAGNOSES:**
   - ☐ Is clinically stable for transplantation based on the prescriber's assessment.
2. **For the treatment of SICKLE CELL DISEASE:**
   - ☐ Has sickle cell disease with confirmatory genetic testing.
   - ☐ At least one of the following:
     - ☐ Has a history of vaso-occlusive episodes (e.g., pain crises, acute chest syndrome, splenic sequestration, priapism) that required a medical facility visit (e.g., emergency department, hospital).
     - ☐ Is currently receiving chronic transfusion therapy for recurrent vaso-occlusive episodes.
3. **For the treatment of TRANSFUSION-DEPENDENT ß-THALASSEMIA:**
   - ☐ Has genetic testing confirming the diagnosis of ß-thalassemia.
   - ☐ Has a history of at least 100 mL/kg/year or 8 transfusion episodes/year of packed red blood cell transfusions in the prior 2 years.

PLEASE FAX COMPLETED FORM WITH SUPPORTING CLINICAL DOCUMENTATION	
Prescriber signature:	Date:

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