

**LYFGENIA**  
**(lovotibeglogene autotemcel)**  
**PRIOR AUTHORIZATION FORM**  
(form effective 1/5/2026)



**Keystone First**

**PERFORMRx**<sup>SM</sup>  
Next Generation Pharmacy Benefits

Fax to PerformRx<sup>SM</sup> at **1-866-497-1387**, or to speak to a representative call **1-800-588-6767**.

| <b>BENEFICIARY INFORMATION</b>   |                               |  |
|--|-------------------------------|--|
| Beneficiary name:  | Beneficiary ID#:              | DOB:   |
| <b>PRESCRIBER INFORMATION</b>  |                               |  |
| Prescriber name:   |                               |  |
| Specialty:   | NPI:                          |  |
| Prescriber address (street/city/state/zip):  |                               |  |
| Prescriber phone:  | Prescriber fax:               |  |
| <b>OFFICE CONTACT INFORMATION</b>  |                               |  |
| Office contact name:   |                               |  |
| Office contact phone:  | Office contact fax:           |  |
| <b>BILLING PROVIDER INFORMATION</b>  |                               |  |
| Billing provider name:   | Billing provider NPI:         |  |
| Billing provider address:  |                               |  |
| <b>CLINICAL INFORMATION</b>  |                               |  |
| Drug name: <b>Lyfgenia</b>   | Beneficiary's weight (kg):    | Dose: _____ x 10 <sup>6</sup> CD34+ cells/kg |
| Place of service:  | Anticipated date of infusion: |  |
| Diagnosis ( <i>submit documentation</i> ):   | Dx code ( <i>required</i> ):  |  |
| <b>INITIAL REQUESTS</b>  |                               |  |
| <p><b>Check all that apply and submit documentation (e.g., recent chart/clinic notes, diagnostic evaluations, test results) for each item.</b></p> <p><input type="checkbox"/> Is clinically stable for transplantation based on the prescriber's assessment.</p> <p><input type="checkbox"/> Has sickle cell disease with confirmatory genetic testing.</p> <p><input type="checkbox"/> At least <u>one</u> of the following:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> 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).</li> <li><input type="checkbox"/> Is currently receiving chronic transfusion therapy for recurrent vaso-occlusive episodes.</li> </ul> |                               |  |
| <b>PLEASE FAX COMPLETED FORM WITH SUPPORTING CLINICAL DOCUMENTATION</b>  |                               |  |
| Prescriber signature:  | Date:                         |  |

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