

ZYNTGLO
(betibeglogene autotemcel)
PRIOR AUTHORIZATION FORM
(form effective 7/15/2024)



Keystone First
Community HealthChoices

PERFORMRxSM
Next Generation Pharmacy Benefits

Fax to PerformRxSM at **1-855-851-4058**, or to speak to a representative call **1-866-907-7088**.

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: Zynteglo	Beneficiary's weight (kg):	Dose: _____ x 10 ⁶ CD34+ cells/kg
Place of service:	Anticipated date of infusion:	
Diagnosis (<i>submit documentation</i>):	Dx code (<i>required</i>):	
INITIAL REQUESTS		
Check all that apply and submit documentation (e.g., recent chart/clinic notes, diagnostic evaluations, test results) for each item.		
<input type="checkbox"/> Has NOT received prior gene therapy.		
<input type="checkbox"/> Has NOT received a prior allogeneic hematopoietic stem cell transplant.		
<input type="checkbox"/> Has genetic testing confirming the diagnosis of β -thalassemia.		
<input type="checkbox"/> 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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