

CASGEVY
(exagamglogene autotemcel)
PRIOR AUTHORIZATION FORM
(form effective 1/5/2026)



Fax to PerformRxSM at **1-888-981-5202**, or to speak to a representative call **1-866-610-2774**.

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: Casgev	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		
Complete all sections that apply to the beneficiary and this request. Check all that apply and <i>submit documentation</i> (e.g., recent chart/clinic notes, diagnostic evaluations, test results) for each item.		
1. For ALL DIAGNOSES: <input type="checkbox"/> Is clinically stable for transplantation based on the prescriber's assessment.		
2. For the treatment of SICKLE CELL DISEASE: <input type="checkbox"/> Has sickle cell disease with confirmatory genetic testing. <input type="checkbox"/> At least <u>one</u> of the following: <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). <input type="checkbox"/> Is currently receiving chronic transfusion therapy for recurrent vaso-occlusive episodes.		
3. For the treatment of TRANSFUSION-DEPENDENT β-THALASSEMIA: <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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