

Clinical Criteria Worksheet: Skysona® (elivaldogene autotemcel)

Enrollee Information

Enrollee Last Name:

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Enrollee First Name:

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Date of Birth (MM/DD/YYYY):

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Enrollee Medicaid ID (2 letters, 5 numbers, 1 letter):

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Address:

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City, Town or Post Office:

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State:

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ZIP Code:

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Prescriber Information

Prescriber Last Name:

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Prescriber First Name:

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National Provider Identifier (NPI) Number:

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Preferred Contact (Telephone Number)

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Enrollee Last Name:

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Enrollee First Name:

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Clinical Criteria

Drug Administration:

Provide the date drug administration (MM/DD/YYYY):

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Provide the expiration date of the drug if the invoice date is greater than six (6) months from the date of drug administration (MM/DD/YYYY):

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Clinical Criteria

1. Does the patient have a diagnosis of early, active cerebral adrenoleukodystrophy (CALD)?

Yes No

2. Is the patient a candidate for allogeneic hematopoietic stem cell transplantation (HSCT), but ineligible due to the absence of a donor?

Yes No

3. Does the patient have human immunodeficiency virus (HIV) or human T-lymphotropic virus (HTLV)?

Yes No

4. Has the patient discontinued anti-retroviral medications for at least one month prior to initiating medications for stem cell mobilization and for the expected duration for elimination of the medications, and until all cycles of apheresis are completed ?

Yes No

5. Has the patient received any previous treatment with Skysona®?

(Skysona® treatment is limited to one treatment per patient for their lifetime.)

Yes No

Enrollee Last Name:

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Enrollee First Name:

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Attestation

I attest that this is medically necessary for this patient and that all of the information on this form is accurate to the best of my knowledge. I attest that documentation of the above diagnosis and medical necessity is available for review if requested by the New York State Medicaid Program.

Prescriber Signature (Required)

Date (MM/DD/YYYY)