



Zynteglo

CareFirst Prior Authorization Request

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-855-330-1720.** If you have questions regarding the prior authorization, please contact CVS Caremark at **1-888-877-0518**. For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

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Patient's Name: _____ **Date:** _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____

Referring Provider Info: Same as Requesting Provider

Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Rendering Provider Info: Same as Referring Provider Same as Requesting Provider

Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Required Demographic Information:

Patient Weight: _____ *kg*

Patient Height: _____ *cm*

Please indicate the place of service for the requested drug:

- Ambulatory Surgical Home Off Campus Outpatient Hospital
 On Campus Outpatient Hospital Office Pharmacy

What is the ICD-10 code? _____

Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-855-330-1720

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received the fax in error, please immediately notify the sender by telephone and destroy the original fax message. Zynteglo C26815-A – 05/2026.

CVS Caremark Specialty Pharmacy • 2211 Sanders Road NBT-6 • Northbrook, IL 60062

Phone: 1-888-877-0518 • Fax: 1-855-330-1720 • www.caremark.com

Clinical Criteria Questions:

1. What is the diagnosis?

Transfusion-dependent beta-thalassemia, *Continue to #2*

Other, *Continue to #2*

2. Has genetic testing been done to confirm the genotype? **Action Required:** If 'Yes', attach molecular or genetic testing results documenting transfusion-dependent beta-thalassemia genotype

Yes, *Continue to #3*

No, *Continue to #3*

3. Does the patient have a non-beta-0/beta-0 OR beta-0/beta-0 genotype confirmed via genetic testing? Note: See Appendix A for examples of non-β0/β0 OR β0/β0 genotypes

Yes, *Continue to #4*

No, *Continue to #4*

4. Does the patient require regular blood cell transfusions?

Yes, *Continue to #5*

No, *Continue to #5*

5. In the past two years, has the patient received at least 100 milliliter per kilogram of packed red blood cells (pRBCs) per year? **Action Required:** If 'Yes', attach chart notes or medical record documenting history of blood cell transfusions for the previous two years

Yes, *Continue to #7*

No, *Continue to #6*

6. In the past two years, has the patient received at least 8 transfusions events of packed red blood cells (pRBCs) per year? **Action Required:** If 'Yes', attach chart notes or medical record documenting history of blood cell transfusions for the previous two years

Yes, *Continue to #7*

No, *Continue to #7*

7. Is the patient eligible for a hematopoietic stem cell transplant (HSCT) but does not have an available and suitable human leukocyte antigen-identical or complete human leukocyte antigen-matched family donor?

Yes, *Continue to #8*

No, *Continue to #8*

8. Has the patient received a prior hematopoietic stem cell transplant (HSCT)?

Yes, *Continue to #9*

No, *Continue to #9*

9. Has the patient previously received the requested medication or any other gene therapy?

Yes, *Continue to #10*

No, *Continue to #10*

10. What is the patient's age at time of treatment decision?

Less than 4 years of age, *Continue to #11*

4 years of age or older, *Continue to #11*

11. What is the patient's weight?

Greater than or equal to 6 kg, *Continue to #12*

Less than 6 kg, *Continue to #12*

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12. Is the patient reasonably anticipated to provide at least the minimum number of cells required to initiate the manufacturing process?

Yes, *Continue to #13*

No, *Continue to #13*

13. Is the requested medication prescribed by or in consultation with a hematologist?

Yes, *No Further Questions*

No, *No Further Questions*

Appendix A

Examples of non-beta-0 OR beta-0 genotypes:

1. Beta-0/beta-0
2. Beta-0/Beta+
3. Beta-E/Beta-0
4. Beta-0/IVS-I-110
5. IVS-I-110/IVS-1-110

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X _____

Prescriber or Authorized Signature

Date (mm/dd/yy)

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