Skysona® (elivaldogene autotemcel) Medication Precertification Request

(All fields must be completed and legible for precertification review.)

Aetna Precertification Notification
Phone: 1-866-752-7021 (TTY: 711)
FAX: 1-888-267-3277

For Medicare Advantage Part B:
Please Use Medicare Request Form

Please indicate: ☐ Start of treatment: Start date ____/____/____
☐ Continuation of therapy, Date of last treatment ____/____/____

Precertification Requested By: ______________________ Phone: ____________ Fax: ____________

A. PATIENT INFORMATION

First Name:	Last Name:	DOB:
Address:	City:	State: ZIP:
Home Phone: Work Phone:	Cell Phone:	Email:
Patient Current Weight: _____ lbs or _____ kgs Patient Height: _____ inches or _____ cms	Allergies:	

B. INSURANCE INFORMATION

Aetna Member ID #: ______________________
Group #: ______________________
Insured:

Does patient have other coverage? ☐ Yes ☐ No
If yes, provide ID#: ______________ Carrier Name: ______________
Insured:

Medicare: ☐ Yes ☐ No If yes, provide ID #: **Medicaid:** ☐ Yes ☐ No If yes, provide ID #:

C. PRESCRIBER INFORMATION

First Name:	Last Name: *(Check One):* ☐ M.D. ☐ D.O. ☐ N.P. ☐ P.A.		
Address:	City:	State:	ZIP:
Phone: Fax:	St Lic #: NPI #:	DEA #:	UPIN:
Provider Email:	Office Contact Name:	Phone:	

Specialty *(Check one)*: ☐ **Neurologist** ☐ **Endocrinologist** ☐ **Other:** ______________________

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration:
☐ Self-administered ☐ Physician's Office
☐ Outpatient Infusion Center Phone: ______________
Center Name: ______________
☐ Home Infusion Center Phone: ______________
Agency Name: ______________
☐ Administration code(s) (CPT): ______________
Address: ______________

Dispensing Provider/Pharmacy: *Patient Selected choice*
☐ Physician's Office ☐ Retail Pharmacy
☐ Specialty Pharmacy ☐ Other
Name: ______________
Address: ______________
Phone: ______________ Fax: ______________
TIN: ______________ PIN: ______________

E. PRODUCT INFORMATION

Request is for: Skysona (elivaldogene autotemcel) Dose: ______________ **Frequency:** ______________

F. DIAGNOSIS INFORMATION - Please indicate primary ICD code and specify any other where applicable.

Primary ICD Code: ☐ ______________ **Secondary ICD Code :** ______________ **Other ICD Code:** ______________

G. CLINICAL INFORMATION - Required clinical information must be completed in its entirety for all precertification requests.

For ALL Requests (clinical documentation required):

☐ Yes ☐ No Does the patient have a diagnosis of cerebral adrenoleukodystrophy (CALD)?
☐ Yes ☐ No Is the patient male?
☐ Yes ☐ No Will the requested medication be prescribed by or in consultation with a prescriber who specializes in the treatment of adrenoleukodystrophy (ALD)?
☐ Yes ☐ No Will the requested drug be used to treat or prevent adrenal insufficiency?
☐ Yes ☐ No Does the patient have cerebral adrenoleukodystrophy (CALD) secondary to head trauma?
☐ Yes ☐ No Does the patient have full deletions of ABCD1 transgene as detected by genetic testing?
☐ Yes ☐ No Does the patient have a pathogenic (or likely pathogenic) variant in the ABCD1 gene as detected by genetic testing?
☐ Yes ☐ No Does the patient have elevated very long chain fatty acids (VLCFA) values per reference range of the laboratory performing the test?
☐ Yes ☐ No Has the patient had a central radiographic review of brain magnetic resonance imaging (MRI) demonstrating early active central nervous (CNS) disease with a Loes score between 0.5 and 9 (inclusive) on the 34-point scale?
→ ☐ Yes ☐ No Does the MRI demonstrate gadolinium enhancement of demyelinating lesions?
☐ Yes ☐ No Does the patient have a Neurologic Function Score (NFS) of less than or equal to 1?
☐ Yes ☐ No Is the patient eligible for hematopoietic stem cell transplant (HSCT) but is unable to find a matched sibling donor?
☐ Yes ☐ No Has the patient previously received the requested drug or any other gene therapy?
☐ Yes ☐ No Has the patient received a prior allogeneic hematopoietic stem cell transplant (allo-HSCT)?

Continued on next page

Skysona® (elivaldogene autotemcel) Medication Precertification Request

(All fields must be completed and legible for precertification review.)

Aetna Precertification Notification
Phone: 1-866-752-7021 (TTY: 711)
FAX: 1-888-267-3277

For Medicare Advantage Part B:
Please Use Medicare Request Form

Patient First Name	Patient Last Name	Patient Phone	Patient DOB

G. CLINICAL INFORMATION ***(continued)*** – Required clinical information must be completed in its entirety for all precertification requests.

☐ Yes ☐ No Will the administration of the requested drug be provided at an Aetna designated gene therapy treatment center?
→ Please indicate the designated gene therapy treatment center: ____________________

H. ACKNOWLEDGEMENT

Request Completed By ***(Signature Required):*** ____________________ **Date:** ____/____/____

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

The plan may request additional information or clarification, if needed, to evaluate requests.