

New Hampshire Medicaid Fee-for-Service Program Prior Authorization Drug Approval Form

Skysona™ (elivaldogene autotemcel)

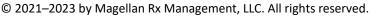
ATE OF MEDICATION REQUEST:	/	

SECTION I: PATIENT INFORMATION AND MEDICATION REQUESTED														
LAST NAME:	FIRST NAME:													
MEDICAID ID NUMBER:	DATE OF BIRTH:													
GENDER: Male Female														
Drug Name:	Strength:													
Dosing Directions:	Length of Therapy:													
SECTION II: PRESCRIBER INFORMATION														
LAST NAME:	FIRST NAME:													
SPECIALTY:	NPI NUMBER:													
PHONE NUMBER:	FAX NUMBER:													
SECTION III: CLINICAL HISTORY														
1. Is the patient a male at least four years of age but less	than 18 years of age? Yes No													
2. Is the diagnosis early, active cerebral adrenoleukodys	trophy (CALD)?													
3. Provide very-long-chain fatty acids (VLCFA) values and	I documentation:													
a. C26:0, 1.30 + 0.45 (normal: 0.23 + 0.09):														
b. C24:0/C22:0, 1.71 + 0.23 (normal: 0.84 + 0.10):														
c. C26:0/C22:0, 0.07 + 0.03 (normal: 0.01 + 0.004): _														
4. Provide genetic testing results showing ABCD1 mutati														

(Form continued on next page.)

Fax to DHHS; medication is administered in inpatient setting:

Phone: 1-603-271-9384 **Fax**: 1-603-314-8101



Review Date: 03/01/2023





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Fax to DHHS; medication is administered in inpatient setting:

Phone: 1-603-271-9384 **Fax**: 1-603-314-8101

(Form continued on next page.)

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Review Date: 03/01/2023





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DATE OF MEDICATION REQUEST:	1 1						
PATIENT LAST NAME:		PATIENT	FIRST NAM	ME:			
SECTION III: CLINICAL HISTORY (Continue	ed)						
Please provide any additional information needed, please use a separate sheet.	i that would he	elp in the de	cision-mal	king proce	ess. If add	itional s	space is
I certify that the information provided is a any falsification, omission, or concealment		-			iminal lia	bility.	erstand tha
PRESCRIBER'S SIGNATURE:					DATE:		
Facility where infusion to be provided:							
Medicaid Provider Number of Facility:							

Fax to DHHS; medication is administered in inpatient setting:

Phone: 1-603-271-9384 **Fax**: 1-603-314-8101

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