

LYFGENIA
(lovotibeglogene autotemcel)
PRIOR AUTHORIZATION FORM
(form effective 1/5/2026)



Fax to PerformRxSM at **1-855-851-4058**, or to speak to a representative call **1-888-674-8720**.

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: Lyfgenia	Beneficiary's weight (kg):	Dose: _____ x 10 ⁶ CD34+ cells/kg
Place of service:	Anticipated date of infusion:	
Diagnosis (submit documentation):	Dx code (required):	

INITIAL REQUESTS
<p>Check all that apply and submit documentation (e.g., recent chart/clinic notes, diagnostic evaluations, test results) for each item.</p> <p><input type="checkbox"/> Is clinically stable for transplantation based on the prescriber's assessment.</p> <p><input type="checkbox"/> Has sickle cell disease with confirmatory genetic testing.</p> <p><input type="checkbox"/> At least <u>one</u> of the following:</p> <ul style="list-style-type: none"> <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.

PLEASE FAX COMPLETED FORM WITH SUPPORTING CLINICAL DOCUMENTATION	
Prescriber signature:	Date:

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