JOHNS HOPKINS HEALTH PLANS	Johns Hopkins Health Plans **Pharmacy Public** **Medical Management Drug Policies**	*Policy Number*	MMDP101
		Effective Date	01/15/2025
		Approval Date	07/17/2024
	Subject **Zynteglo**	*Supersedes Date*	N/A
		Page	1 of 3

This document applies to the following Participating Organizations:

US Family Health Plan

Keywords: Zynteglo

Table of Contents		Page Number
I.	POLICY	1
II.	POLICY CRITERIA	1
III.	AUTHORIZATION PERIOD/LIMITATIONS	1
IV.	EXCLUSIONS	2
V.	RECOMMENDED DOSE	2
VI.	CODES	2
VII.	REFERENCES	2
VIII.	APPROVALS	2

I. POLICY

A. Zynteglo (betibeglogene autotemcel) will require prior authorization for medical benefit coverage to ensure appropriate use. The process for initiating a prior authorization request can be found in policy PHARM 20.

II. POLICY CRITERIA

A. Zynteglo may be approved for patients who meet the following:
   1. Patient is 4 years of age or older and weighs at least 6 kg
   2. Patient is reasonably anticipated to provide at least the minimum number of cells required to initiate the manufacturing process
   3. Documentation has been submitted showing all the following:
      a. Diagnosis of transfusion-dependent beta-thalassemia with a non-#0/#0 OR #0/#0 genotype confirmed via genetic testing, such one of the following:
         I. beta0/beta0
         II. beta0/beta+
         III. betaE/beta0
         IV. beta0/IVS-I-110
         V. IVS-I-110/IVS-1-110
      b. Patient requires regular blood cell transfusions, and also has received one of the following with the previous two years:
         I. At least 100 milliliter per kilogram of packed red blood cells (pRBCs) per year
         II. At least 8 transfusions events of pRBCs per year
      c. Patient is eligible for a hematopoietic stem cell transplant (HSCT) but is unable to find a human leukocyte antigen (HLA)-matched related donor
      d. Patient has not received a prior HSCT
      e. Patient has not previously received Lyfgenia or any other gene therapy

III. AUTHORIZATION PERIOD/LIMITATIONS

A. Approval will be limited to 3 months for a one-time administration.

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IV. EXCLUSIONS

A. Zynteglo will not be covered for the following:
   1. Patients with any of the following:
      a. Positive test for human immunodeficiency virus type 1 or 2 (HIV-1 and HIV-2)
      b. Positive test for hepatitis B virus (HBV) or hepatitis C (HCV)
      c. Any prior or current malignancy
      d. Advanced liver disease (e.g., bridging fibrosis, cirrhosis, active hepatitis)
      e. Severely elevated iron in the heart (i.e., patients with cardiac T2* less than 10 msec by MRI)
   2. Any indications or uses that are not FDA-approved, or guideline-supported

V. RECOMMENDED DOSE

Please refer to the FDA-approved prescribing information, or clinical guidelines, for indication-specific dosing details.

VI. CODES

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Note: The following CPT/HCPCS codes are included below for informational purposes. Inclusion or exclusion of a CPT/HCPCS code(s) below does not signify or imply member coverage or provider reimbursement. The member's specific benefit plan determines coverage.

Medication	HCPCS/CPT Code
Injection, betibeglogene autotemcel, per treatment	J3393

VII. REFERENCES

1. Zynteglo [prescribing information]. Somerville, MA: Bluebird Bio; August 2022.
2. Locatelli F, Thompson AA, Kwiatkowski JL, et al. Betibeglogene Autotemcel Gene Therapy for Non-beta0/beta0 Genotype beta-Thalassemia. N Engl J Med. 2022;386(5):415-427.
3. Ashutosh Lal, Franco Locatelli, Janet L. Kwiatkowski, Andreas E. Kulozik, Evangelia Yannaki, John B. Porter, Isabelle Thuret, Martin G. Sauer, Heidi Elliot, Ying Chen, Richard A. Colvin, Alexis A. Thompson; Northstar-3: Interim Results from a Phase 3 Study Evaluating Lentiglobin Gene Therapy in Patients with Transfusion-Dependent #-Thalassemia and Either a beta0 or IVS-I-110 Mutation at Both Alleles of the HBB Gene. Blood 2019; 134 (Supplement_1): 815.
4. Cappellini MD, Farmakis D, Porter J, Taher A. 2021 Guidelines for the management of transfusion dependent thalassaemia (TDT). Nicosia, Cyprus: Thalassaemia International Federation, 2021.

VIII. APPROVALS

Signature on file at JHHP

DATE OF REVISION	SUMMARY OF CHANGE
07/17/2024	Policy creation

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		Page	3 of 3

01/15/2025	Removed prescriber specialty requirement

Review Date: 07/17/2024

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