Michigan Department of Health and Human Services
Program Policy Division PO Box 30809
Lansing MI 48909

MDHHS
Michigan Department of Health & Human Services
GRETCHEN WHITMER, GOVERNOR | ELIZABETH HERTEL, DIRECTOR

December 23, 2025

<Provider Name>
<Provider Address 1>
<Provider Address 2>
<City> <State> zipcode5-zipcode4

Dear Provider:

RE: Coverage Criteria for Certain Cell and Gene Therapies

This letter notifies providers of the publication by the Michigan Department of Health and Human Services (MDHHS) of prior authorization coverage criteria as required for participation in the Center for Medicare and Medicaid Innovation (CMMI) Cell and Gene Therapy (CGT) Access Model. The CMMI CGT Access Model supports state Medicaid program coverage of gene therapies delivered under the Centers for Medicare & Medicaid Services (CMS) negotiated outcomes-based agreements.

Prior authorization (PA) coverage criteria for the gene therapies Casgevy, Lyfgenia, and any future therapies selected for the CGT Access Model can be found at www.michigan.gov >> Medicaid Providers >> CHAMPS >> Prior Authorization >> Cell and Gene Therapy Access Model Coverage Criteria. PA requests for these cell and gene therapies must be submitted to MDHHS for Medicaid Health Plan (MHP) enrollees and Fee-for-Service (FFS) beneficiaries.

PA requests for the admission and/or services associated with the administration of gene therapies, where applicable, are to be submitted to the MHP for MHP enrollees and to MDHHS for FFS beneficiaries. For more information about submitting requests for PA, refer to the General Information for Providers chapter in the MDHHS Medicaid Provider Manual.

Medical necessity is established by meeting the coverage criteria but is not a guarantee of beneficiary eligibility or payment. Medical necessity determinations will continue to be considered for beneficiaries that may not meet all published criteria. Providers must continue to adhere to all applicable Medicaid policies and procedures, including PA submission and documentation requirements.

An electronic version of this document is available at www.michigan.gov/medicaidproviders >> Policy, Letters & Forms.

Sincerely,

Meghan E. Groen, Chief Deputy Director
Health Services

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Casgevy Proposed Coverage Criteria

Casgevy (exagamglogene autotemcel)

Length of Authorization: 12 months

Criteria to Approve

- Patient is ≥ 12 years of age; **AND**
- Diagnosis of Sickle Cell Disease (SCD) with confirmatory genetic testing; **AND**
- Prior use, failure, intolerance, or patient/family refusal of hydroxyurea (per health care professional judgement) at any point in the past; **AND**
- Patient is clinically stable and fit for transplantation; **AND**
- Prescribed by or in consultation with a board-certified hematologist with SCD expertise; **AND**
- Patient has experienced two or more documented Vaso-Occlusive Crises (VOCs) per year in the previous twenty-four (24) months, based on provider attestation; **OR**
- Patient currently receiving chronic transfusion therapy for recurrent VOCs (based on provider attestation).

Lyfgenia Proposed Coverage Criteria

Lyfgenia (lovotibeglogene autotemcel)

Length of Authorization: 12 months

Criteria to Approve

- Patient is ≥ 12 years of age at the expected time of administration; **AND**
- Diagnosis of Sickle Cell Disease (SCD) with confirmatory genetic testing; **AND**
- Prior use, failure, intolerance, or patient/family refusal of hydroxyurea (per health care professional judgement) at any point in the past; **AND**
- Patient is clinically stable and fit for transplantation; **AND**
- Prescribed by or in consultation with a board-certified hematologist with SCD expertise; **AND**
- Eligible Beneficiary's Treatment Center has a Sickle Cell Center; **AND**
- Patient currently receiving chronic transfusion therapy for recurrent Vaso-Occlusive Events (VOEs); **OR**
- Patient has experienced four (4) or more VOEs in previous twenty-four (24) months as determined by the Eligible Beneficiary's treating clinician.