Aetna Better Health of Texas
PROVIDER NOTIFICATION

Dear Valued Provider,

Effective for dates of service October 25, 2025, providers must obtain prior authorization for atidarsagene autotemcel (Lenmeldy), procedure code J3391.

Prior Authorization Requirements for AtidarsageneAutotemcel (Lenmeldy)

Atidarsagene autotemcel (Lenmeldy) is an autologous hematopoietic stem cell–based gene therapy (HSCT) and a once-per-lifetime infusion that is indicated for a client who meets all the following requirements:

- The client is 7 years of age or younger, or they are between 7 years and 17 years of age with the onset of symptoms before 7 years of age.
- The client has a documented biochemical and molecular diagnosis of one of the following forms of metachromatic leukodystrophy (MLD) (diagnosis code E7525):
    - Presymptomatic late infantile
    - Presymptomatic early juvenile (PSEJ)
    - Early symptomatic early juvenile
- The client has an MLD diagnosis that is confirmed by:
    - Biochemical testing indicating arylsulfatase A (ARSA) activity below the normal range.
    - Genetic testing that shows the presence of two disease-causing ARSA alleles.
    - A 24-hour urine collection showing elevated sulfatide levels if ARSA mutations are present.
- The client is a candidate for and has not previously received HSCT.
- The client will not take prophylactic human immunodeficiency virus (HIV) anti-retroviral medications for at least one month before mobilization or for the expected duration of time needed for the elimination of medications.

Required Monitoring Parameters

The client must be monitored for all the following parameters after atidarsagene autotemcel (Lenmeldy) infusion:

- Signs and symptoms of encephalitis, thrombocytopenia, and serious infection post infusion
- Signs and symptoms of veno-occlusive disease, according to the results of liver function tests during the first month post infusion
- Lifelong hematologic malignancies, according to the results of an annual complete blood count (with differential) and integration site analysis, as warranted, for at least 15 years post infusion

Please refer to the provider pre-authorization tool for the most up to date listing of codes requiring a prior authorization https://www.aetnabetterhealth.com/texas/providers/prior-authorization.html

Please note: This new process may result in a change in how your practice is reimbursed for these services. We urge you to thoroughly review the information in this document and in the attached policy.

CHIP
Bexar area
1-866-818-0959 **(TTY: 711)**
Tarrant area
1-800-245-5380 **(TTY: 711)**

STAR (Medicaid)
Bexar area
1-800-248-7767 **(TTY: 711)**
Tarrant area
1-800-306-8612 (TTY: 711)

STAR Kids
Dallas and Tarrant areas
1-844-787-5437 **(TTY: 711)**

Thank you for your valued partnership in caring for our Aetna Better Health Members.
Sincerely,

Provider Services and Chief Medical Officer
Aetna Better Health of Texas