FAX Completed Form To
1.877.386.4695

Provider Help Desk
1.866.399.0928

Request for Prior Authorization
VOXELOTOR (OXBRYTA)

(PLEASE PRINT – ACCURACY IS IMPORTANT)

IA Medicaid Member ID #	Patient name	DOB
Patient address		
Provider NPI	Prescriber name	Phone
Prescriber address		Fax
Pharmacy name	Address	Phone
Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.		
Pharmacy NPI	Pharmacy fax	NDC

Prior authorization is required for Oxbryta (voxelotor). Payment will be considered for patients when the following criteria are met:

1) **Patient meets the FDA approved age; and**
2) **Patient has a diagnosis of sickle cell disease (SCD); and**
3) **Requested dose is within the FDA approved dosing; and**
4) **Patient has experienced at least two sickle cell-related vasoocclusive crises within the past 12 months (documentation required); and**
5) **Patient has documentation of an adequate trial and therapy failure with hydroxyurea; and**
6) **Baseline hemoglobin (Hb) range is ≥5.5 to ≤10.5 g/dL; and**
7) **Is prescribed by or in consultation with a hematologist; and**
8) **Patient is not receiving concomitant blood transfusion therapy.**

If the criteria for coverage are met, an initial authorization will be given for 6 months. Additional approvals will be granted if the following criteria are met:

1) **Documentation of an increase in hemoglobin by ≥1 g/dL from baseline; and**
2) **Documentation of a decrease in the number of sickle cell-related vasoocclusive crises.**

The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.

Non-Preferred

☐ Oxbryta

Strength	Dosage Instructions	Quantity	Days Supply

Diagnosis: _____

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Request for Prior Authorization-*Continued*
VOXELOTOR (OXBRYTA)

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Treatment failures:

Hydroxyurea Trial:

Drug name & dose:_____ Trial dates:_____

Reason for failure:_____

Has patient experienced at least two sickle cell-related vasoocclusive crises within the past 12 months?

☐ No ☐ Yes (provide documentation)

Baseline Hb: _____ Date obtained: _____

Is Prescriber a hematologist?

❑ **Yes**

❑ **No** If no, note consultation with hematologist:

Consultation Date:_____ Physician Name & Phone: _____

Is patient receiving concomitant blood transfusion therapy? ☐ No ☐ Yes

<u>Renewal Requests</u>

Provide current Hb: _____ Date obtained: _____

Has patient experienced a decrease in the number of sickle cell-related vasoocclusive crises?

☐ No ☐ Yes

Possible drug interactions/conflicting drug therapies:_____

Attach lab results and other documentation as necessary.

Prescriber signature (Must match prescriber listed above.)	Date of submission

IMPORTANT NOTE: *In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.*