



Request for Prior Authorization VOXELOTOR (OXBRYTA)

(PLEASE PRINT - ACCURACY IS IMPORTANT)

FAX Completed Form To 1.833.404.2392

Pharmacy Help Desk 1.800.460.8988

Prescriber Help Desk 1.833.587.2012

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				
 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:				



Treatment failures:



Request for Prior Authorization-Continued VOXELOTOR (OXBRYTA)

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Hydroxyurea Trial:				
Drug name & dose: Tr	ial 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				
Renewal Requests				
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.

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