



FAX Completed Form To
 1.833.404.2392
Pharmacy Help Desk
 1.800.460.8988
Prescriber Help Desk
 1.833.587.2012

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

(PLEASE PRINT – ACCURACY IS IMPORTANT)

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

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
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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.