Voxelotor (Oxbryta) Prior Authorization of Benefits Form

CONTAINS CONFIDENTIAL PATIENT INFORMATION
Complete form in its entirety and fax to: Prior Authorization of Benefits Center at 1-844-512-9004 or Provider Help Desk at 1-800-454-3730.

1. Patient information	**2. Physician information**
Patient name: ______________________________	Prescribing physician: ____________________________
Patient ID #: ________________________________	Physician address: _______________________________
Patient DOB: ______________________________	Physician phone #:_______________________________
Date of Rx: _________________________________	Physician fax #: _________________________________
Patient phone #: ____________________________	Physician specialty: ______________________________
Patient email address: _______________________	Physician DEA: __________________________________
	Physician NPI #: _________________________________
	Physician email address: __________________________

3. Medication	**4. Strength**	**5. Directions**	**6. Quantity per 30 days**
_____________________	____________________	__________________	Specify: _________________________

7. Diagnosis: ____

8. Approval criteria: (Check all boxes that apply. Note: Any areas not filled out are considered not applicable to your patient and may affect the outcome of this request.)

Prior authorization is required for Voxelotor (Oxbryta). 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 six 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

Treatment failures:
Hydroxyurea trial:
Drug name and 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 and 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.

9. Physician signature

____ Prescriber or authorized signature	____________________________ Date
Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations and exclusions. The submitting provider certifies that the information provided is true, accurate and complete and the requested services are medically indicated and necessary to the health of the patient. Note: Payment is subject to member eligibility. Authorization does not guarantee payment.	