MHS PHARMACY BENEFIT
SICKLE CELL AGENTS PRIOR AUTHORIZATION REQUEST FORM

MHS
550 N. Meridian St. Suite 101
Indianapolis, IN, 46204-1208
Phone: (877) 647-4848 Fax: (866) 399-0929

Today's Date
☐☐ / ☐☐ / ☐☐☐☐

Note: This form must be completed by the prescribing provider.
****All sections must be completed or the request will be returned****

Patient's Medicaid # ☐☐☐☐☐☐☐☐☐☐☐☐	Date of Birth ☐☐ / ☐☐ / ☐☐☐☐
Patient's Name	Prescriber's Name
Prescriber's IN License # ☐☐☐☐☐☐☐☐	Specialty
Prescriber's NPI # ☐☐☐☐☐☐☐☐☐☐	Prescriber's Signature
Return Fax # ☐☐☐ - ☐☐☐ - ☐☐☐☐	Return Phone # ☐☐☐ - ☐☐☐ - ☐☐☐☐
Check box if requesting retro-active PA ☐	Date(s) of service requested for retro-active eligibility (if applicable):

Note: Submit PA requests for retroactive claims (dates of service prior to eligibility determination, but within established eligibility timelines) with dates of service prior to 30 calendar days of submission separately from current PA requests (dates of service 30 calendar days or less and going forward).

PA Requirements:

Adakveo (crizanlizumab) PA Requirements

1. Request is for:
   - ☐ Initiation of therapy
   - ☐ Continuation of therapy (refill)
2. Member is 16 years of age or older ☐ Yes ☐ No
3. Diagnosis:
   - ☐ Sickle cell disease (including, but not limited to, homozygous hemoglobin S, sickle hemoglobin C disease, sickle beta⁰ thalassemia, and sickle beta+ thalassemia)
   - ☐ Other: _____
4. Member's current weight: _____

   Requested dose:
   - ☐ 5 mg/kg IV at week 0, week 2, and every 4 weeks thereafter
   - ☐ Other:_____
5. Prescribed by, or in consultation with, a hematologist or other prescriber specialized in the treatment of sickle cell disease ☐ Yes ☐ No
6. Member is currently receiving hydroxyurea therapy ☐ Yes ☐ No

OR

Member has a history of intolerance or contraindication to hydroxyurea therapy □ Yes □ No

7. **Initiation only:** Member experienced TWO sickle cell-related vaso-occlusive crisis events within the previous 12 months while concurrently receiving hydroxyurea therapy (or member has an intolerance or contraindication to hydroxyurea therapy) □ Yes □ No
   Dates: _____

Endari (L-glutamine) PA Requirements

1. Request is for:
   □ Initiation of therapy
   □ Continuation of therapy (refill)
2. Member is 5 years of age or older AND has diagnosis of sickle cell disease, including, but not limited to, homozygous hemoglobin S, sickle hemoglobin C disease, sickle beta^0 thalassemia, and sickle beta+ thalassemia □ Yes □ No
3. Prescribed by, or in consultation with, a hematologist or other prescriber specialized in the treatment of sickle cell disease □ Yes □ No
4. Member is currently receiving hydroxyurea therapy □ Yes □ No
   OR
   Member has a history of intolerance or contraindication to hydroxyurea therapy □ Yes □ No
5. **Initiation only:** Member experienced TWO sickle cell-related vaso-occlusive crisis events within the previous 12 months while concurrently receiving hydroxyurea therapy (or member has an intolerance or contraindication to hydroxyurea therapy) □ Yes □ No
   Dates:_____
6. Member is 18 years of age or older AND has one of the following diagnoses:
   □ Short bowel syndrome (see questions 7 & 8)
   □ Mucositis following chemotherapy (see question 9)
   □ Prophylaxis of peripheral neuropathy due to oxaliplatin or high-dose paclitaxel use (see question 9)
7. If member is diagnosed with short bowel syndrome, is member using recombinant human growth hormone concurrently with L-glutamine therapy □ Yes □ No

   If not, please provide rationale: _____
   _____
   _____
8. Prescribed by, or in consultation with, a gastroenterologist or other prescriber specialized in the treatment of short bowel syndrome □ Yes □ No
9. If member is diagnosed with mucositis following chemotherapy and/or prophylaxis of peripheral neuropathy due to oxaliplatin or high-dose paclitaxel use, prescribed by, or in consultation with, an oncologist □ Yes □ No
10. Requested dose does not exceed 30 grams (6 x 5 gm packets) daily for all of the above indications □ Yes □ No

Oxbryta (voxelotor) PA Requirements

1. Request is for:

   □ Initiation of therapy

   □ Continuation of therapy (refill)

2. Member is 4 years of age or older □ Yes □ No

3. Diagnosis:
   □ Sickle cell disease (including, but not limited to, homozygous hemoglobin S, sickle hemoglobin C disease, sickle beta^0 thalassemia, and sickle beta+ thalassemia)
   □ Other: _____

4. Requested dose:
   □ 1,500 mg per day (3 x 500mg tablets) for members ≥ 12 years of age or members between 4 and 11 years of age weighing ≥ 40 kg
   □ 900 mg per day (3 x 300mg tablets for suspension or 3 x 300 mg tablets) for members between 4 and 11 years of age weighing ≥ 20 kg and < 40 kg
   □ 600 mg per day (2 x 300mg tablets for suspension or 2 x 300 mg tablets) for members between 4 and 11 years of age weighing ≥ 10 kg and < 20 kg
   □ Rationale for certain formulation over other: _____

5. Prescribed by, or in consultation with, a hematologist or other prescriber specialized in the treatment of sickle cell disease □ Yes □ No

6. Member is currently receiving hydroxyurea therapy □ Yes □ No
   OR
   Member has a history of intolerance or contraindication to hydroxyurea therapy □ Yes □ No

7. **Initiation only*:**

   Member is 12 years of age or older and has experienced one sickle cell-related vaso-occlusive crisis within the previous 12 months while concurrently receiving hydroxyurea therapy (or member has an intolerance or contraindication to hydroxyurea therapy) □ Yes □ No

   Dates:_____

Note: members 4-11 years of age do NOT need to have experienced any sickle-cell related vaso-occlusive crisis events