

SENTARA HEALTH PLANS

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request. All other information may be filled in by office staff; **fax to 1-800-750-9692**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process may be delayed.**

Drug Requested: Oxbryta[®] (voxelotor)

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member Sentara #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

DEA OR NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy:** _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight (kg): _____

Part A

- **Vaso-occlusive crises (VOC):** defined as acute episodes of pain that were caused by a vaso-occlusive event that resulted in a **visit to a medical facility** and treatment with oral or parenteral opioids or parenteral nonsteroidal anti-inflammatory drugs. **ICD codes for VOC and pharmacy claims from within the last 12 months will be verified.**
- **ICD CODES for Crisis while in ER/INPATIENT:** 282.42, 282.62, 282.64, 282.69, D57.0, D57.00, D57.01, D57.02, D57.21, D57.211, D57.212, D57.219, D57.41, D57.411, D57.419 D57.3, D57.412, D57.81, D57.811, D57.812, D57.819

Recommended Dosing:

- Adults and pediatric patients 12 years of age or older: 1,500 mg orally once daily
- Children 4 years of age to less than 12 years of age:
 - 10 to < 20 kg: 600 mg orally once daily
 - 20 to < 40 kg: 900 mg orally once daily
 - ≥ 40 kg: 1,500 mg orally once daily

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CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

Initial Authorization: 6 months

- ☐ Provider is a hematologist, has been in consultation with one, or a specialist in treating patients with sickle cell disease
- ☐ Member is 4 years of age or older
- ☐ Member has a confirmed medical history or diagnosis of sickle cell disease:
 - ☐ HbSS ☐ HbSC ☐ HbSB0-thalassemia ☐ HbSB+-thalassemia
 - ☐ Other: _____
- ☐ Member has experienced at least 1 vaso-occlusive crises (defined in Part A) within the preceding 12 months as determined by medical documentation with ICD codes
- ☐ **ONE** of the following must be met:
 - ☐ Oxbryta® (voxelotor) therapy will be taken concomitantly with hydroxyurea
 - ☐ Member had an insufficient response to at least 90 consecutive days of treatment with hydroxyurea within 12 months of this request (**defined as >2 VOCs as detailed in Part A; paid pharmacy claims for hydroxyurea and Droxia within the last 12 months will be verified**)
 - ☐ Member cannot take hydroxyurea due to contraindications of severe bone marrow depression (e.g., leukopenia [$<2,500/\text{mm}^3$], thrombocytopenia [$<100,000/\text{mm}^3$], or severe anemia that requires transfusion (**Labs completed within the last 30 days documenting contraindication must be submitted**))
- ☐ Member has symptomatic anemia with a baseline hemoglobin level between ≥ 6.0 g/dL and ≤ 10.5 g/dL (**Labs completed within the last 30 days documenting hemoglobin level must be submitted**)
- ☐ A baseline measure of blood counts has been submitted, to include indirect bilirubin and percent reticulocytes (**Labs completed within the last 30 days must be submitted**)
- ☐ Member is **NOT** receiving regularly scheduled therapy from a chronic red blood cell transfusion program (**Recent chart notes detailing medical history, transfusion history, and clinical plans must be submitted with this request**)
- ☐ Requested medication is **NOT** initiated during an aplastic episode (hemoglobin concentration 2 g/dL or more below baseline or less than 6 g/dL when the baseline is not recorded or known)
- ☐ Member is **NOT** concomitantly receiving Adakveo® (crizanlizumab) or Endari® (L-glutamine oral powder). **If member is currently on Adakveo® or Endari®, then Oxbryta® will be denied.**

Reauthorization: 12 months. Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

- ☐ **ONE** of the following continues to be met:
 - ☐ Oxbryta® (voxelotor) therapy will be taken concomitantly with hydroxyurea

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- ☐ Member had an insufficient response to at least 90 consecutive days of treatment with hydroxyurea within 12 months of this request (**defined as >2 VOCs as detailed in Part A; paid pharmacy claims for hydroxyurea and Droxia within the last 12 months will be verified**)
- ☐ Member cannot take hydroxyurea due to contraindications of severe bone marrow depression (e.g., leukopenia [$<2,500/\text{mm}^3$], thrombocytopenia [$<100,000/\text{mm}^3$], or severe anemia that requires transfusion (**Labs completed within the last 30 days documenting contraindication must be submitted**)
- ☐ Member's hemoglobin levels have demonstrated an increase $>1\text{g/dL}$ from baseline (**Labs completed within the last 30 days documenting hemoglobin level must be submitted**)
- ☐ Documentation of a positive clinical response to Oxbryta[®] (voxelotor) therapy demonstrated by ONE of the following must be met (**Labs completed within the last 30 days must be submitted**):
 - ☐ Decrease in indirect bilirubin from baseline
 - ☐ Decrease in percent reticulocyte count from baseline

Medication being provided by Specialty Pharmacy - PropriumRx

Not all drugs may be covered under every Plan

If a drug is non-formulary on a Plan, documentation of medical necessity will be required.

*****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.*****

****Previous therapies will be verified through pharmacy paid claims or submitted chart notes.****