

SENTARA COMMUNITY PLAN (MEDICAID)

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 can be delayed.

Sickle Cell Disease Drugs

Drug Requested: (Please select drug below)

PREFERRED MEDICATIONS (Does not require Prior Authorization for FDA approved ages)	
<input type="checkbox"/> Droxia®	<input type="checkbox"/> Endari™
<input type="checkbox"/> Siklos® (age 2-17 requires no PA)	<input type="checkbox"/> Xromi® (hydroxyurea) solution (PA required if 2 years of age or older)
NON-PREFERRED MEDICATIONS (Require prior authorization)	
<input type="checkbox"/> Adakveo IV®	<input type="checkbox"/> L-glutamine (generic Endari™)

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: _____

NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Name/Form/Strength: _____

Dosing Schedule: _____ Length of Therapy: _____

Diagnosis: _____ ICD Code, if applicable: _____

Weight (if applicable): _____ Date weight obtained: _____

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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 Approval: 6 months

1. Is the drug being prescribed by or in consultation with an oncologist, hematologist or sickle cell specialist?
☐ Yes ☐ No
2. Does the patient have a diagnosis of Sickle Cell Disease presenting as one of following (HbSS, HbSC, HbS β^0 -thalassemia, or HbS β^+ -thalassemia)?
☐ Yes ☐ No
3. Is the medication dose proper for the patient's age or other conditions affecting the dose, according to the product package insert approved by the FDA?
☐ Yes ☐ No

For Adakveo®

4. Has the member had an insufficient response to a minimum 3-month trial of hydroxyurea (unless contraindicated or intolerant)?
☐ Yes ☐ No
5. Patient has experienced **TWO** or more vaso-occlusive crises (VOC) in the previous year despite adherence to hydroxyurea therapy?
☐ Yes ☐ No

For Siklos®

6. Is the member 18 years of age or older?
☐ Yes ☐ No
7. Is the brand Siklos medically necessary? If yes, provide explanation below
☐ Yes ☐ No

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For Xromi (hydroxyurea solution)

8. Is the member 2 years of age or older? ☐ Yes ☐ No
9. Is the Xromi solution medically necessary? If yes, please provide explanation below ☐ Yes ☐ No

For generic glutamine powder packet:

10. Has the member had an insufficient response to a minimum 3-month trial of brand name Endari®? ☐ Yes ☐ No

Reauthorization Approval: 1 year. 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.

1. Does the member continue to meet the above criteria? ☐ Yes ☐ No
2. Does the member have disease response improvement with treatment? ☐ Yes ☐ No

For Adakveo®:

3. Is the member's response compared to pre-treatment baseline evidenced by a decrease in the frequency of vaso-occlusive crises (VOC) necessitating treatment, reduction in number or duration of hospitalizations, and/or reduction in severity of VOC? ☐ Yes ☐ No

List pharmaceutical drugs attempted and outcome:

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Medical necessity: Provide clinical evidence that the **PREFERRED** drug(s) will **not** provide adequate benefit.

*****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.****