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)	
❑ **Droxia®**	❑ **Endari™**
❑ **Siklos®** (age 2-17 requires no PA)	
NON-PREFERRED MEDICATIONS (Require prior authorization)	
❑ **Adakveo IV®**	❑ **L-glutamine (generic Endari™)**
❑ **Xromi® (hydroxyurea) solution**	

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, HbSβ⁰-thalassemia, or HbSβ⁺-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

   _____

   _____

   _____

For generic glutamine powder packet:

8. Has the member had an insufficient response to a minimum 3-month trial of brand name Endari® ?

   ❑ Yes ❑ No

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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:

_____

_____

_____

_____

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.****

REVISED/UPDATED/REFORMATTED: ~~11/16/2022; 12/27/2022; 11/8/2023, 10/2/2024;~~ ~~12/11/2024,~~ **9/10/2025**