



Request for Prior Authorization
VOXELOTOR (OXBRYTA)

(PLEASE PRINT - ACCURACY IS IMPORTANT)

Form with fields for IA Medicaid Member ID #, Patient name, DOB, Patient address, Provider NPI, Prescriber name, Phone, Prescriber address, Fax, Pharmacy name, Address, Phone, Pharmacy NPI, Pharmacy fax, NDC.

Prior authorization is required for Oxbryta (voxelotor). 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 6 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

Strength

Dosage Instructions

Quantity

Days Supply

Diagnosis:

**Request for Prior Authorization-Continued  
VOXELOTOR (OXBRYTA)**

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**Treatment failures:**

**Hydroxyurea Trial:**

Drug name & 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 & 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.***

|  |                    |
|--|--------------------|
| Prescriber signature (Must match prescriber listed above.) | Date of submission |
|--|--------------------|

**IMPORTANT NOTE:** In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.