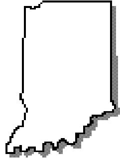
INDIANA HEALTH COVERAGE PROGRAMS (IHCP) PHARMACY BENEFIT
SICKLE CELL AGENTS PRIOR AUTHORIZATION (PA) REQUEST FORM



CareSource Pharmacy Prior Authorization Form
P.O. Box 8738
Dayton, OH 45401-8738
Fax: 866-930-0019

Today's Date ☐☐ / ☐☐ / ☐☐☐☐ Non-Urgent ☐ Urgent ☐

Note: This form must be completed by the prescribing provider.

*****All sections must be completed or the request will be returned.*****

Member's CareSource ID	Member's Date of Birth ☐☐ / ☐☐ / ☐☐☐☐
Member's Name	Prescriber's Name
Prescriber's Indiana License #	Specialty
Prescriber's NPI #	Office Contact
Prescriber's Fax ☐☐☐ - ☐☐☐ - ☐☐☐☐	Prescriber's Phone ☐☐☐ - ☐☐☐ - ☐☐☐☐
Prescriber's Address	Date(s) of Service Requested: Start Date:

Requested Medication	Strength	Quantity	Directions for Use

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 beta° thalassemia, and sickle beta+ thalassemia) **Diagnosis Code:** ____________
   ☐ Other: ______________________________ **Diagnosis Code:** ______________

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

   If "Yes" to 7, please provide 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° thalassemia, and sickle beta+ thalassemia? ☐ Yes ☐ No

   Diagnosis Code: ________________________
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

   If Yes to 5, please provide dates: __________________________________
6. Member is 18 years of age or older AND has one of the following diagnoses:
   - ☐ Short bowel syndrome (see questions 7 and 8)
   - ☐ Mucositis following chemotherapy (see question 9)
   - ☐ Prophylaxis of peripheral neuropathy due to oxaliplatin or high-dose paclitaxel use (see question 9)

   Diagnosis Code: ______________
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

I attest that the provided information above is accurate:

Physician Signature: __________________________________ **Date: _____________**

CONFIDENTIAL INFORMATION

This facsimile and any attached document are confidential and are intended for the use of individual or entity to which it is addressed. If you have received this in error, please notify us by telephone immediately at **1-844-607-2831**.