CareSource Rxinnovations

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

CareSource Pharmacy Prior Authorization Form
CareSource
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.*****

Patient's CareSource # ☐☐☐☐☐☐☐☐☐☐☐☐	Date of Birth ☐☐ / ☐☐ / ☐☐☐☐
Patient'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) Prior Authorization (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^0 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^0 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 & 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

Oxbryta (voxelotor) PA Requirements

1. Request is for:
   - ☐ Initiation of therapy
   - ☐ Continuation of therapy (refill)

2. Member is 4 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^0 thalassemia, and sickle beta+ thalassemia) **Diagnosis Code: _____**

☐ Other: _____ **Diagnosis Code: _____**

4. Requested dose:

☐ 1,500 mg per day (3-500mg tablets) for members ≥ 12 years of age or members between 4 and 11 years of age weighing ≥ 40 kg

☐ 900 mg per day (3-300mg tablets for suspension or 3 x 300 mg tablets) for members between 4 and 11 years of age weighing ≥ 20 kg and < 40 kg

☐ 600 mg per day (2 x 300mg tablets for suspension or 2 x 300 mg tablets) for members ≥12 years of age or members between 4 and 11 years of age weighing ≥10 kg and < 20 kg

☐ Rationale for certain formulation over 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 is 12 years of age or older and has experienced one sickle cell-related vaso-occlusive crisis 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: _____

Note: Members 4-11 years of age do NOT need to have experienced any sickle-cell related vaso-occlusive crisis events.

I attest that the provided information above is accurate:

Physician Signature: _____ **Date: _____**