Updated: 01/2020
DMMA Approved: 02/2020

Request for Prior Authorization for Oxbryta (voxelotor)
Website Form – www.highmarkhealthoptions.com
Submit request via: Fax - 1-855-476-4158

All requests for Oxbryta (voxelotor) require a Prior Authorization and will be screened for medical necessity and appropriateness using the criteria listed below.

Oxbryta (voxelotor) Prior Authorization Criteria:

Coverage may be provided with a diagnosis of the treatment of Sickle Cell Disease and the following criteria is met:

- Member is 12 years of age or older.
- Diagnosis is confirmed by electrophoresis demonstrating the presence of sickle cell disease (HbSS, HbSC, HbSβ^0-thalassemia, or HbSβ^+-thalassemia).
- Member must have a hemoglobin ≥5.5 g/dL.
- Must be prescribed by or in association with hematologist/oncologist or sickle cell disease specialist.
- Must provide documentation showing the member has tried and failed (which will be verified via pharmacy claims if available) or had an intolerance or contraindication to at least a 6 month trial of hydroxyurea.
- Member must have had at least 1 vaso-occlusive crisis in the past 12 months.
- Member must not have severe renal dysfunction (estimated glomerular filtration rate at the Screening visit; calculated by the central laboratory) <30 mL/min/1.73 m^2 or on chronic dialysis.
- The requested dose and frequency is in accordance with FDA-approved labeling, nationally recognized compendia, and/or evidence-based practice guidelines.
- **Initial Duration of Approval:** 6 months
    - There must be clinical documentation that there has been a reduction in vaso-occlusive events, and/or increased hemoglobin response rate defined as a Hb increase of more than 1 g/dL.
- **Reauthorization Duration of Approval:** 12 months

Highmark Delaware HEALTH OPTIONS

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OXBRYTA (VOXELOTOR)
PRIOR AUTHORIZATION FORM

Please complete and fax all requested information below including any progress notes, laboratory test results, or chart documentation as applicable to Highmark Health Options Pharmacy Services. **FAX:** (855) 476-4158
If needed, you may call to speak to a Pharmacy Services Representative.
PHONE: (844) 325-6251 Monday through Friday 8:30am to 5:00pm

PROVIDER INFORMATION

Requesting Provider:	NPI:
Provider Specialty:	Office Contact:
Office Address:	Office Phone:
	Office Fax:

MEMBER INFORMATION

Member Name:	DOB:
Health Options ID:	Member weight: _____pounds or _____kg

REQUESTED DRUG INFORMATION

Medication:	Strength:
Frequency:	Duration:
Is the member currently receiving requested medication? ☐ Yes ☐ No	Date Medication Initiated:

Is this medication being used for a chronic or long-term condition for which the medication may be necessary for the life of the patient? ☐ Yes ☐ No

Billing Information

This medication will be billed: ☐ at a pharmacy **OR**
☐ medically (if medically please provide a JCODE:_____

Place of Service: ☐ Hospital ☐ Provider's office ☐ Member's home ☐ Other

Place of Service Information

Name:	NPI:
Address:	Phone:

MEDICAL HISTORY (Complete for ALL requests)

1. Is member 12 years of age or older?
   ☐ Yes ☐ No

2. Has the diagnosis is confirmed by electrophoresis demonstrating the presence of sickle cell disease (HbSS, HbSC, HbSβ^0-thalassemia, or HbSβ^+-thalassemia)?
   ☐ Yes ☐ No

3. Does the member have a hemoglobin ≥5.5 g/dL?
   ☐ Yes ☐ No

4. Will the medication be prescribed by or in association with hematologist/oncologist or sickle cell disease specialist?
   ☐ Yes ☐ No

5. Is the documentation showing the member has tried and failed (which will be verified via pharmacy claims if available) or had an intolerance or contraindication to at least a 6 month trial of hydroxyurea? If yes, please attach documentation.
☐ Yes ☐ No

6. Has the member had at least 1 vaso-occlusive crisis in the past 12 months?
☐ Yes ☐ No

7. Does the member have severe renal dysfunction (estimated glomerular filtration rate at the Screening visit; calculated by the central laboratory) <30 mL/min/1.73 m^2 or on chronic dialysis?
☐ Yes ☐ No

CURRENT or PREVIOUS THERAPY			
Medication Name	**Strength/ Frequency**	**Dates of Therapy**	**Status (Discontinued & Why/Current)**

REAUTHORIZATION

Is there clinical documentation that there has been a reduction in vaso-occlusive events and/or increased hemoglobin response rate defined as a Hb increase of more than 1 g/dL?
☐ Yes ☐ No

Please describe:

SUPPORTING INFORMATION or CLINICAL RATIONALE

Prescribing Provider Signature	Date