Updated: 01/2020
PARP Approved: 02/2020

Prior Authorization Criteria
Oxbryta (voxelotor)

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

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

Coverage may be provided for any non-FDA labeled indication if it is determined that the use is a medically accepted indication supported by nationally recognized pharmacy compendia or peer-reviewed medical literature for treatment of the diagnosis(es) for which it is prescribed. These requests will be reviewed on a case by case basis to determine medical necessity.

When criteria are not met, the request will be forwarded to a Medical Director for review. The physician reviewer must override criteria when, in their professional judgment, the requested medication is medically necessary.

Gateway Health

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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 Gateway Health℠ Pharmacy Services. **FAX:** (888) 245-2049
If needed, you may call to speak to a Pharmacy Services Representative.
PHONE: (800) 392-1147 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:
Gateway 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:

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^{o}-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