Gateway Health
It's Wholecare.

Gateway Health Plan
Pharmacy Division
Phone 800-392-1147 Fax 888-245-2049

# I. Requirements for Prior Authorization of Sickle Cell Anemia Agents

## A. Prescriptions That Require Prior Authorization

Prescriptions for Sickle Cell Anemia Agents that meet any of the following conditions must be prior authorized:

1. A non-preferred Sickle Cell Anemia Agent. See the Preferred Drug List (PDL) for the list of preferred Sickle Cell Anemia Agents at: https://papdl.com/preferred-drug-list.

## B. Review of Documentation for Medical Necessity

In evaluating a request for prior authorization of a prescription for a Sickle Cell Anemia Agent, the determination of whether the requested prescription is medically necessary will take into account whether the beneficiary:

1. Is prescribed the Sickle Cell Anemia Agent for an indication that is included in the U.S. Food and Drug Administration (FDA)-approved package labeling OR a medically accepted indication; **AND**

2. Is age-appropriate according to FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature; **AND**

3. Is prescribed a dose that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature; **AND**

4. Is prescribed the Sickle Cell Anemia Agent by or in consultation with a hematologist/oncologist or sickle cell disease specialist; **AND**

5. Had all potential drug interactions addressed by the prescriber (such as discontinuation of the interacting drug, dose reduction of the interacting drug, or counseling of the beneficiary of the risks associated with the use of both medications when they interact); **AND**

6. Has a history of therapeutic failure, contraindication, or intolerance to maximum tolerated doses of hydroxyurea for at least 6 months

NOTE: If the beneficiary does not meet the clinical review guidelines listed above but, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the beneficiary, the request for prior authorization will be approved.

FOR RENEWALS OF PRIOR AUTHORIZATION FOR SICKLE CELL ANEMIA AGENTS: The determination of medical necessity of a request for renewal of a prior authorization for a Sickle Cell Anemia Agent that was previously approved will take into account whether the beneficiary:

1. Has documentation of tolerability and a positive clinical response to the medication; **AND**

2. Is prescribed a dose that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature; **AND**

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3. Is prescribed the Sickle Cell Anemia Agent by or in consultation with a hematologist/oncologist or sickle cell disease specialist; **AND**

4. Had all potential drug interactions addressed by the prescriber (such as discontinuation of the interacting drug, dose reduction of the interacting drug, or counseling of the beneficiary of the risks associated with the use of both medications when they interact)

   NOTE: If the beneficiary does not meet the clinical review guidelines listed above but, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the beneficiary, the request for prior authorization will be approved.

C. Clinical Review Process

Prior authorization personnel will review the request for prior authorization and apply the clinical guidelines in Section B. above to assess the medical necessity of a prescription for a Sickle Cell Anemia Agent. If the guidelines in Section B. are met, the reviewer will prior authorize the prescription. If the guidelines are not met, the prior authorization request will be referred to a physician reviewer for a medical necessity determination. Such a request for prior authorization will be approved when, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the beneficiary.

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# SICKLE CELL ANEMIA AGENTS PRIOR AUTHORIZATION FORM

| | | | |
|---|---|---|---|
| ☐New request ☐Renewal request | # of pages: _____ | Prescriber name: | |
| Name of office contact: | | Specialty: | |
| Contact's phone number: | | NPI: | State license #: |
| LTC facility contact/phone: | | Street address: | |
| Beneficiary name: | | Suite #: | City/State/Zip: |
| Beneficiary ID#: | DOB: | Phone: | Fax: |

## CLINICAL INFORMATION

| | | | |
|---|---|---|---|
| Non-preferred drug requested: | Strength: | Formulation (powder, tablet, etc.): | |
| Dose/directions: | | Quantity: | Refills: |
| Diagnosis *(submit documentation)*: | | Dx code (*required*): | |
| Is the medication being prescribed by or in consultation with a hematologist/oncologist or sickle cell disease specialist? | | ☐Yes ☐No | *Submit documentation of consultation, if applicable.* |
| **INITIAL requests** | | | |
| Does the beneficiary have a history of therapeutic failure of maximum tolerated doses of hydroxyurea for a period of at least 6 months? | | ☐Yes ☐No | *Submit documentation.* |
| Does the beneficiary have a contraindication or intolerance to hydroxyurea? | | ☐Yes ☐No | *Submit documentation.* |
| **RENEWAL requests** | | | |
| Has the beneficiary experienced a positive clinical response to the requested medication? | | ☐Yes ☐No | *Submit documentation.* |

## PLEASE FAX COMPLETED FORM TO GATEWAY – PHARMACY DIVISION

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|---|---|
| Prescriber Signature: | Date: |