Updated: 02/2021
DMMA Approved: 03/2021

Request for Prior Authorization for Sickle Cell Agents
Website Form – www.highmarkhealthoptions.com
Submit request via: Fax - 1-855-476-4158

All requests for Sickle Cell Agents require a prior authorization and will be screened for medical necessity and appropriateness using the criteria listed below.

Sickle Cell Agents include Adakveo (crizanlizumab-tmca) and Oxbryta (voxelotor). New products with this classification will require the same documentation

Sickle Cell Agents Prior Authorization Criteria:

For all requests for Sickle Cell Agents, all of the following criteria must be met:

- Must be prescribed by or in consultation with a hematologist/oncologist or sickle cell disease specialist.
- Diagnosis is confirmed by electrophoresis demonstrating the presence of sickle cell disease (HbSS, HbSC, HbSβ^0-thalassemia, or HbSβ^+-thalassemia).
- 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 (may require prior authorization).
- The requested dose and frequency is in accordance with FDA-approved labeling, nationally recognized compendia, and/or evidence-based practice guidelines

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

Adakveo (crizanlizumab-tmca) only:
- Member must be 16 years of age or older.
- Member must have had at least 2 vaso-occlusive crises in the past 12 months.
- **Initial Duration of Approval:** 6 months
- **Reauthorization criteria**
  - Documentation the member has experienced a reduction in sickle cell-related vasoocclusive crises and/or a decrease in severity of sickle cell related vasocculsive crises from pretreatment baseline while on Adakveo
- **Reauthorization Duration of Approval:** 12 months

Oxbryta (voxelotor) only:
- Member is 12 years of age or older.
- Member must have a hemoglobin ≥5.5 g/dL to ≤10.5 g/dL
- Member must have had at least 1 vaso-occlusive crisis in the past 12 months.
- **Initial Duration of Approval:** 6 months
  - Documentation of 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.

Drugs are authorized in generic form unless the branded product is on the preferred drug list or the prescriber has indicated in writing that the branded product is medically necessary. If only the branded product is on the preferred drug list, the generic form will be considered non-preferred and shall not require the prescriber to indicate in writing that the branded product is medically necessary.

HIGHMARK. Delaware HEALTH OPTIONS

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SICKLE CELL AGENTS
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)

- Has the diagnosis been confirmed by electrophoresis demonstrating the presence of sickle cell disease (HbSS, HbSC, HbSβ^0-thalassemia, or HbSβ^+-thalassemia)?
  ☐ Yes ☐ No
- Does the member have a hemoglobin ≥5.5 g/dL to ≤10.5 g/dL? (Oxbryta only)
  ☐ Yes ☐ No
- Is the medication being prescribed by or in association with hematologist/oncologist or sickle cell disease specialist?
  ☐ Yes ☐ No
- Has the member tried and failed or had an intolerance or contraindication to a 6 month trial of hydroxyurea?
  ☐ Yes ☐ No
- Has the member had at least 2 vaso-occlusive crises in the past 12 months? (Adakveo only)
  ☐ Yes ☐ No
- Has the member had at least 1 vaso-occlusive crisis in the past 12 months? (Oxbryta only)
  ☐ Yes ☐ No

CURRENT or PREVIOUS THERAPY

Medication Name	Strength/ Frequency	Dates of Therapy	Status (Discontinued & Why/Current)

REAUTHORIZATION

Has the member experienced a reduction in sickle cell-related vaso-occlusive crises and/or a decrease in severity of sickle cell related vaso-occlusive crises from pretreatment baseline while on therapy? ☐ Yes ☐ No

Has there 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

BENLYSTA (BELIMUMAB)
PRIOR AUTHORIZATION FORM

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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)

Diagnosis: ☐ Systemic lupus erythematosus ☐ Lupus nephritis ☐ Other: _____
ICD-10: _____

- Does the member have a clinical diagnosis of SLE according to the American College of Rheumatology classification criteria? ☐ Yes ☐ No
- Does the member have active disease? ☐ Yes ☐ No
- Please provide member's baseline SELENA-SLEDAI score: _____
- Is the anti-nuclear antibody (ANA) titer ≥ 1:80? ☐ Yes ☐ No
- Is the anti-double stranded DNA (anti-dsDNA) ≥ 30 IU/mL? ☐ Yes ☐ No

For lupus nephritis:

- Does the member have a clinical diagnosis of SLE according to the American College of Rheumatology classification criteria? ☐ Yes ☐ No
- Does the member have active disease? ☐ Yes ☐ No
- Does the member have a biopsy-proved lupus nephritis Class III, IV and/or V? ☐ Yes ☐ No

Has the member tried standard of care medications for SLE or lupus nephritis? ☐ Yes, please list below ☐ No

Does the member have severe active central nervous system (CNS) lupus? ☐ Yes ☐ No

Will the member be using other biologics or IV cyclophosphamide in combination with this medication? ☐ Yes ☐ No

CURRENT or PREVIOUS THERAPY

Medication Name	Strength/ Frequency	Dates of Therapy	Status (Discontinued & Why/Current)

REAUTHORIZATION

Has the member tolerated and experienced a clinical benefit from treatment? ☐ Yes ☐ No
Please describe:

SUPPORTING INFORMATION or CLINICAL RATIONALE

Prescribing Provider Signature	Date