# Nevada Medicaid

Submit fax request to: 855-455-3303

Please note: All information below is required to process this request.

## Sickle Cell Anemia Agents Prior Authorization Request Form

**DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED.**

| Member Information (required) | | | Provider Information (required) | | |
|---|---|---|---|---|---|
| Member Name: | | | Provider Name: | | |
| Insurance ID#: | | | NPI#: | Specialty: | |
| Date of Birth: | | | Office Phone: | | |
| Street Address: | | | Office Fax: | | |
| City: | State: | Zip: | Office Street Address: | | |
| Phone: | | | City: | State: | Zip: |

| Medication Information (required) | | |
|---|---|---|
| Medication Name: | Strength: | Dosage Form: |
| ❑ Check if requesting **brand** | Directions for Use: | |
| ❑ Check if request is for **continuation of therapy** | | |

### Clinical Information (required)

**Select the diagnosis below:**

❑ Sickle Cell Disease

❑ Other diagnosis: _____ ICD-10 Code(s): _____

### Drug-Specific Information (required)

#### Adakveo® (crizanlizumab-tmca)

❑ The recipient is 16 years of age or older

❑ The recipient has documentation of <u>two</u> vaso-occlusive events requiring medical facility visits and treatments in the past 12 months (e.g., sickle cell crisis, acute pain episodes, acute chest syndrome, hepatic sequestration, splenic sequestration, priapism)

Indicate which of the following the recipient has tried and failed or the recipient has a contraindication or intolerance:

- ❑ Hydroxyurea
- ❑ L-glutamine (i.e., Endari)

❑ The medication is prescribed by or in consultation with a Hematologist/Oncologist or a specialist with expertise in the diagnosis and management of sickle cell disease

❑ If the request is for continuation of therapy, the recipient has documentation of positive clinical response to Adakveo® therapy (e.g., reduction in annual rate of vaso-occlusive events, increased time between each vaso-occlusive event)

#### Oxbryta® (voxelotor)

❑ The recipient is 12 years of age or older

❑ The recipient has documentation of <u>one</u> vaso-occlusive crisis (VOC) event within the past 12 months (e.g., sickle cell crisis, acute painful crisis, acute chest syndrome)

❑ The recipient has documentation of hemoglobin level that does not exceed 10.5 g/dL prior to therapy initiation

❑ The recipient has documentation of trial and failure, contraindication, or intolerance to hydroxyurea

❑ The medication is prescribed by or in consultation with a Hematologist/Oncologist or a specialist with expertise in the diagnosis and management of sickle cell disease

❑ If the request is for continuation of therapy, the recipient has documentation of positive clinical response to Oxbryta® therapy (e.g., an increase in hemoglobin level of greater than or equal to one g/dL from baseline, decreased annualized incidence rate of VOCs)

**Attach any additional comments, diagnoses, symptoms, medications tried or failed, or other information the physician feels is important to this review.**

<u>Please note</u>: This request may be denied unless all required information is received. For urgent or expedited requests please call 1-800-711-4555. This form may be used for non-urgent requests and faxed to 1-800-527-0531.