UTAH MEDICAID PHARMACY PRIOR AUTHORIZATION REQUEST FORM

Oxbryta (voxelotor)

Member and Medication Information * indicates required field	
*Member ID:	*Member Name:
*DOB:	*Weight:
*Medication Name/ Strength:	
☐ Do Not Substitute. Authorizations will be processed for the preferred Generic/Brand equivalent unless specified.	
*Directions for use:	
Provider Information * indicates required field	
*Requesting Provider Name:	*Requesting Prescriber NPI:
Address:	
*Contact Person:	*Office Phone:
*Office Fax:	*Office Email:
Medically Billed Information * indicates required field for all medically billed products	
*Diagnosis Code:	*HCPCS Code:
*Dosing Frequency:	*HCPCS Units per Dose:
Servicing Provider Name:	NPI:
Servicing Provider Address:	
Facility/Clinic Name:	NPI:
Facility/Clinic Address:	
Fax form and relevant documentation including: laboratory results, chart notes and/or updated provider letter to Pharmacy PA at **855-828-4992**, to prevent processing delays.	

Criteria for Approval: (*All* of the following criteria must be met):

1. Is the patient 4 years of age or older? ❑ **Yes** ❑ **No**
2. Does the patient have a diagnosis of sickle cell disease ? ❑ **Yes** ❑ **No**
3. Is the medication being prescribed by or in consultation with a hematologist specializing in the treatment of sickle cell disease? ❑ **Yes** ❑ **No**
4. Does the patient have symptomatic or severe anemia despite at least 4 months of therapy with a maximally tolerated dose of hydroxyurea? ❑ **Yes** ❑ **No**
5. Does the patient have a hemoglobin level of 10.5 g/dL or less? ❑ **Yes** ❑ **No**
6. Has the provider verified that the patient has not received red blood cell transfusions within 30 days? ❑ **Yes** ❑ **No**

Reauthorization Criteria:

1. Has the patient had an increase in hemoglobin from the baseline hemoglobin level since starting the medication? Chart note page #: ________ ❑ **Yes** ❑ **No**

Initial Authorization: Up to six (6) months

Reauthorization: Up to one (1) year

PROVIDER CERTIFICATION

I hereby certify this treatment is indicated, necessary and meets the guidelines for use.

Prescriber's Signature ______________________ Date __________