Prior Authorization Request Form for
voxelotor **(Oxbryta)**

JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE
7231 Parkway Drive, Suite 100, Hanover, MD 21076

FAX Completed Form and Applicable Progress Notes to: (410) 424-4037

USFHP Pharmacy Prior Authorization Form

To be completed by Requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

Step 1 **Please complete patient and physician information** (please print):

Patient Name: _____ Physician Name: _____
Address: _____ Address: _____
_____ _____
Sponsor ID # _____ Phone #: _____
Date of Birth: Secure Fax #:

Step 2 **Please complete the clinical assessment:**

1. **Has the patient received this medication under the TRICARE benefit in the last 6 months?** ***Please choose "No" if the patient did not previously have a TRICARE approved PA for Oxbryta***	☐ **No** – Proceed to question **2** ☐ **Yes** – Proceed to question **9**	
2. **Does the patient meet FDA-indicated age requirements?**	☐ Yes Proceed to question **3**	☐ No **STOP** **Coverage not approved**
3. **For which indication is the requested medication being prescribed?**	☐ **Sickle cell disease** – Proceed to question **4** ☐ **Other** – **STOP Coverage not approved**	
4. **Has the patient had at least one vaso-occlusive crisis in the last 12 months AND has a hemoglobin between 5.5 g/dL and 10.5 g/dL?**	☐ Yes Proceed to question **5**	☐ No **STOP** **Coverage not approved**
5. **Has the patient had an inadequate treatment response to a 3 month trial of hydroxyurea?**	☐ Yes Proceed to question **6**	☐ No **STOP** **Coverage not approved**
6. **Is the requested medication prescribed by or in consultation with a hematologist?**	☐ Yes Proceed to question **7**	☐ No **STOP** **Coverage not approved**

Prior Authorization Request Form for voxelotor **(Oxbryta)**

7. Is the patient on a strong or moderate CYP3A4 inducer (e.g. carbamazepine, phenytoin, rifampin, etc.)?	☐ Yes Proceed to question **8**	☐ No **Sign and date below**
8. Does the provider acknowledge that prior to starting Oxbryta, the patient should be switched to a drug that does not interact with Oxbryta. If, and only if, this is not possible, provider should continue the CYP3A4 inducer and increase the dose of Oxbryta per the package insert.	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**
9. Is there documented improvement in hemoglobin by greater than or equal to 1 g/dL from baseline?	☐ Yes **Sign and date below**	☐ No Proceed to question **10**
10. Has the patient demonstrated a decreased number of vaso-occlusive crises by greater than or equal to 1 crisis per year from baseline in past 12 months?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**

Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date:

_____ _____

Prescriber Signature Date

[13 May 2020]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: