Prior Authorization Request Form for
hydroxyurea (**Siklos**)

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

USFHP Pharmacy Prior Authorization Form

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

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. Is this request for malignance, including chronic myelocytic leukemia or other cancers?	☐ Yes **STOP** **Coverage not approved**	☐ Yes Proceed to question **2**
2. 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 Siklos*	☐ Yes (subject to verification) Proceed to question **5**	☐ No Proceed to question **3**
3. Is the patient 18 years of age or older?	☐ Yes Proceed to question **4**	☐ No **STOP** **Prior authorization not required**
4. Please explain why the patient cannot use the preferred product generic hydroxyurea or Droxia.	**Sign and date below**	
5. Does the patient continue to have swallowing difficulties that preclude the use of hydroxyurea 200 mg, 300 mg, 400 mg, or 500 mg capsules?	☐ Yes Proceed to question **6**	☐ No **STOP** **Coverage not approved**

6. Has the patient been monitored and has had at least two laboratory draws in the last year and has not developed hematologic toxicity (Toxic hematologic ranges: Neutrophils less than 2,000/mm3; platelets less than 80,000/mm3; hemoglobin less than 4.5 g/dL; and reticulocytes less than 80,000/mm3 if hemoglobin is less than 9 g/dL)?	☐ Yes Proceed to question **7**	☐ No **STOP** **Coverage not approved**
7. Has the patient achieved a stable dose with no hematologic toxicity for 24 weeks?	☐ 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

[31 July 2019]

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