Aetna Better Health® of Virginia Request Form

Service Sickle Cell Disease Drugs

Fax back to 1-855-799-2553

If the following information is not complete, correct, or legible, the PA process can be delayed. Please use one form per member.

Preferred drugs Droxia®, Endari®, and Oxbryta® do not require a PA.

MEMBER INFORMATION

Last Name:

First Name:

Medicaid ID Number:

Date of Birth: – –

Gender: ☐ **Male** ☐ **Female**

Weight in Kilograms: ______________________________

PRESCRIBER INFORMATION

Last Name:

First Name:

NPI Number:

Phone Number: – –

Fax Number: – –

DRUG INFORMATION

Drug Name/Form: ☐ Adakveo® ☐ Siklos®

Strength: ______________________________

Dosing Frequency: ______________________________

Length of Therapy: ______________________________

Quantity per Day: ______________________________

(Form continued on next page.)

Member's Last Name: | | | | | | | | | | | | |

Member's First Name: | | | | | | | | | | | | |

DIAGNOSIS AND MEDICAL INFORMATION

For initial approval, complete the following questions to receive a 6-month approval:

1. Is the drug being prescribed by or in consultation with an oncologist, hematologist, or sickle cell specialist?
   ☐ Yes ☐ No
2. Does the patient have a diagnosis of sickle cell disease presenting as one of following: HbSS, HbSC, HbSβ^0-thalassemia, or HbSβ^+-thalassemia? AND
   ☐ Yes ☐ No
3. Is the medication dose proper for the patient's age or other conditions affecting the dose, according to the FDA-approved product package insert?
   ☐ Yes ☐ No

*** For Adakveo®:**

4. Has the patient had an insufficient response to a minimum 3-month trial of hydroxyurea (unless contraindicated or intolerant)?
   ☐ Yes ☐ No
5. Has the patient experienced **TWO** or more vaso-occlusive crises (VOC) in the previous year, despite adherence to hydroxyurea therapy? AND
   ☐ Yes ☐ No

**** For Siklos® (hydroxyurea):**

6. Is the member 2 to 17 years of age?
   ☐ Yes ☐ No

For renewal, complete the following questions to receive a 12-month approval:

7. Does the member continue to meet the above criteria? AND
   ☐ Yes ☐ No
8. Does the member have disease response improvement with treatment?
   ☐ Yes ☐ No

**** For Adakveo®:**

9. Is the member's response compared to pre-treatment baseline evidenced by a decrease in the frequency of vaso-occlusive crises (VOC) necessitating treatment, reduction in number or duration of hospitalizations, and/or reduction in severity of VOC?
   ☐ Yes ☐ No

(Form continued on next page.)

Member's Last Name: | | | | | | | | | | | | |

Member's First Name: | | | | | | | | | | | | |

______________________________________ ______________

Prescriber Signature (Required) **Date**

By signature, the physician confirms the above information is accurate and verifiable by member records.

Please include ALL requested information; incomplete forms will delay the PA process.
Submission of documentation does NOT guarantee coverage.