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United Healthcare Community Plan

COMMONWEALTH OF VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

Service Authorization (SA) Form

SICKLE CELL DISEASE DRUGS

If the following information is not complete, correct, or legible, the SA process can be delayed.

Please use one form per member.

Preferred drugs Droxia® Endari®, and Siklos® (if age 2–17) do not require a SA.

MEMBER INFORMATION

Last Name: _____

First Name: _____

Medicaid ID Number: _____

Date of Birth: _____

Weight in Kilograms: _____

PRESCRIBER INFORMATION

Last Name: _____

First Name: _____

NPI Number: _____

Phone Number: _____

Fax Number: _____

DRUG INFORMATION

Drug Name/Form: ☐ Adakveo® ☐ Siklos® (if 18 years of age or older) ☐ glutamine powder packet

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 member 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 member's age or other conditions affecting the dose, according to the FDA-approved product package insert?
   ☐ Yes ☐ No

*** For Adakveo®:**

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

**** For Siklos® (hydroxyurea):**

6. Is the member 18 years of age or older?
   ☐ Yes ☐ No
7. Is the brand Siklos® medically necessary? If yes, please provide explanation below.
   ☐ Yes ☐ No

_____

***For generic glutamine powder packet:**

8. Has the member had an insufficient response to a minimum 3-month trial of brand name Endari®?
   ☐ Yes ☐ No

(Form continued on next page.)

Member's Last Name: **Member's First Name:**

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

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

**** For Adakveo®:**

3. 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

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 SA process.
Submission of documentation does NOT guarantee coverage by the Department of Medical Assistance Services.

Fax this form to 1-866-940-7328

Pharmacy PA call center: 1-800-310-6826