Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.
OXBRYTA (Voxelotor) Prior Authorization (PA)
Pharmacy Benefits Prior Authorization Help Desk
Length of Authorizations: Initial- 6 months; Continuation- 12 months

Instructions:

This form is used by Kaiser Permanente and/or participating providers for coverage of **OXBRYTA (Voxelotor).** Please complete all sections, incomplete forms will delay processing. Fax this form back to Kaiser Permanente within 24 hours fax: 1-866-331-2104. If you have any questions or concerns, please call 1-866-331-2103. **Requests will not be considered unless all sections are complete.**

KP-MAS Formulary can be found at: Pharmacy | Community Provider Portal | Kaiser Permanente

1 – Patient Information

Patient Name: _____ Kaiser Medical ID#: _____ Date of Birth: _____

2 – Prescriber Information

Prescriber Name: _____ Specialty: _____ NPI: _____

Prescriber Address: _____

Prescriber Phone #: _____Prescriber Fax #: _____

Do you have an approved provider referral number from Kaiser Permanente?
□ Yes – please provide your provider referral number here: _____

3 – Pharmacy Information

Pharmacy Name: _____ Pharmacy NPI: _____

Pharmacy Phone #_____ Pharmacy Fax #: _____

4 – Drug Therapy Requested

Drug 1: Name/Strength/Formulation: _____
Sig: _____

Drug 2: Name/Strength/Formulation: _____
Sig: _____

5– Diagnosis/Clinical Criteria

1. Is this request for initial or continuing therapy?
   □ Initial therapy □ Continuing therapy, State start date: _____

2. Indicate the Member's diagnosis for the requested medication: _____

Clinical Criteria:

1. Is the prescriber a hematology-oncology specialist?
   □ No □ Yes

2. Is the member ≥4 years of age?
   □ No □ Yes

3. Was the member diagnosed with sickle cell anemia or hemoglobin S (HbS) beta thalassemia (documented by hemoglobin electrophoresis)?
   □ No □ Yes

4. Is the member's hemoglobin level ≤10.5 g/dL prior to treatment?
   □ No □ Yes

5. Is there documentation of one of the following:
   a. Transfusion-dependent anemia with alloantibodies
   b. Symptomatic anemia without transfusion dependence
   c. Pulmonary hypertension and hypoxia
   □ No □ Yes

For Continuation of Therapy, Please Respond to Additional Questions Below:

1. Reassess to determine need for continued therapy. Does the patient meet either of the following criteria? (if yes, therapy should be discontinued)
   a. Lack of efficacy (e.g., no increase in Hb that leads to a decrease in transfusion requirement and/or symptoms)
   b. Non-adherence to the medication
   □ No □ Yes

6 – Prescriber Sign-Off

Additional Information –

1. **Please submit chart notes/medical records for the patient that are applicable to this request.**
2. **If member has not tried preferred agent(s) please provide rationale/explanation and any additional supporting information that should be taken into consideration for the requested medication:**

_____

_____

_____

I certify that the information provided is accurate. Supporting documentation is available for State audits.

Prescriber Signature:	**Date:**