AETNA BETTER HEALTH® OF VIRGINIA REQUEST FORM

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.

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 PA process.
Submission of documentation does NOT guarantee coverage.