SICKLE CELL ANEMIA AGENTS PRIOR AUTHORIZATION FORM *(form effective 3/30/2026)*

FAX this completed form to (844) 205-3386
OR Mail requests to: Pharmacy Department | 5 River Park Place East, Suite 210 | Fresno, CA 93720
OR Prior authorization may be completed at https://www.covermymeds.com/main/prior-authorization-forms/

Prior authorization guidelines for **Sickle Cell Anemia Agents** and **Quantity Limits/Daily Dose Limits** are available on the PA Health & Wellness website at https://www.pahealthwellness.com/providers/pharmacy.html.

☐New request ☐Renewal request	# of pages: _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		NPI:	State license #:
LTC facility contact/phone:		Street address:	
Member name:		City/State/Zip:	
Member ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Drug requested:	Strength:	Formulation (powder, tablet, etc.):	
Dose/directions:		Quantity:	Refills:
Diagnosis *(submit documentation)*:		Dx code (*required*):	
Is the medication being prescribed by or in consultation with a hematologist/oncologist or sickle cell disease specialist?		☐Yes ☐No	*Submit documentation of consultation, if applicable.*

Complete all sections that apply to the member and this request.
Check all that apply and submit documentation for each item.

INITIAL requests

1. **For a ADAKVEO (crizanlizumab-tmca) or L-GLUTAMINE powder:**

   ☐Tried and failed or has a contraindication or an intolerance to maximum tolerated doses of hydroxyurea for at least 6 months

2. **For SIKLOS (hydroxyurea) tablet for a member 18 YEARS OF AGE OR OLDER:**

   ☐Is unable to obtain a hydroxyurea dose that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature with the preferred hydroxyurea capsule *(Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred drugs in this class.)*

3. **For a NON-PREFERRED HYDROXYUREA Sickle Cell Anemia Agent** *(Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred drugs in this class.)*:

☐ Tried and failed or has a contraindication or an intolerance to the preferred hydroxyurea Sickle Cell Anemia Agents that would not be expected to occur with the requested drug

☐ Is unable to obtain a hydroxyurea dose that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature with the preferred hydroxyurea Sickle Cell Anemia Agents

RENEWAL requests

1. **For ALL renewal requests:**

   ☐ Has documentation of a positive clinical response to the requested drug

2. **For SIKLOS (hydroxyurea) tablet for a member 18 YEARS OF AGE OR OLDER:**

   ☐ Is unable to obtain a hydroxyurea dose that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature with the preferred hydroxyurea capsule *(Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred drugs in this class.)*

3. **For a NON-PREFERRED HYDROXYUREA Sickle Cell Anemia Agent** *(Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred drugs in this class.)*:

   ☐ Tried and failed or has a contraindication or an intolerance to the preferred hydroxyurea Sickle Cell Anemia Agents that would not be expected to occur with the requested drug

   ☐ Is unable to obtain a hydroxyurea dose that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature with the preferred hydroxyurea Sickle Cell Anemia Agents

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO 844-205-3386

Prescriber Signature:	**Date:**

Pharmacy Department will respond via fax or phone within 24 hours.
Requests for prior authorization (PA) requests must include member name, ID#, and drug name. Please include lab reports with requests when appropriate (e.g., Culture and Sensitivity; Hemoglobin A1C; Serum Creatinine; CD4; Hematocrit; WBC, etc.)