HEALTH PARTNERS PLANS
Phone 215-991-4300 Fax 1-866-240-3712

FAX FORM AND CLINICAL DOCUMENTATION

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

Prior authorization guidelines for **Sickle Cell Anemia Agents** and **Quantity Limits/Daily Dose Limits** are available on the DHS Pharmacy Services website at https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/default.aspx.

☐ 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:	
Beneficiary name:		City/State/Zip:	
Beneficiary 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 beneficiary 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 beneficiary 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 beneficiary 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 866-240-3712

Prescriber Signature:	**Date:**