aetna™

Aetna Better Health®

Fax completed prior authorization request form to 855-799-2551 or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts.

All requested data must be provided. **Incomplete forms or forms without the chart notes will be returned**

Pharmacy Coverage Guidelines are available at www.aetnabetterhealth.com/michigan/providers/medicaid/pharmacy

Oxbryta
Pharmacy Prior Authorization Request Form

Do not copy for future use. Forms are updated frequently.

REQUIRED: Office notes, labs and medical testing relevant to request showing medical justification to support diagnosis

Member Information			
Member Name (first & last):	Date of Birth:	Gender: ☐ Male ☐ Female	Height:
Member ID:	City:	State:	Weight:

Prescribing Provider Information			
Provider Name (first & last):	Specialty:	NPI#	DEA#
Office Address:	City:	State:	Zip Code:
Office Contact:	Office Phone		Office Fax:

Dispensing Pharmacy Information		
Pharmacy Name:	Pharmacy Phone:	Pharmacy Fax:

Requested Medication Information				
Medication request is NOT for FDA approved or compendia-supported diagnosis (circle one): ☐ Yes ☐ No	Diagnosis:	ICD-10 Code:		
Are there any contraindications to formulary medications? If yes, specify:		☐ Yes	☐ No	☐ New request
☐ Continuation of therapy ONLY:	Has the member shown an increase in hemoglobin from baseline? If **YES**, please submit supporting documentation.	☐ Yes	☐ No	
	Does the provider attest to other positive clinical response? If **YES**, please submit supporting documentation.	☐ Yes	☐ No	

Directions for Use:	Strength:		Dosage Form:
	Quantity:	Day Supply:	Duration of Therapy/Use:
What medication(s) has the member tried and failed for this diagnosis? Please specify below.			

Turn-Around Time for Review	
☐ Standard – (24 hours)	☐ **Urgent** – waiting 24 hours for a standard decision could seriously harm life, health, or ability to regain maximum function, you can ask for an expedited decision. Signature: _____

Clinical Information					
Is the requested drug prescribed by, or in consultation, with a hematologist or other specialist with expertise in the diagnosis and management of sickle cell disease?				☐ Yes	☐ No
Does the member have baseline hemoglobin level between 5.5 g/dL and 10.5g/dL?				☐ Yes	☐ No
Is the request for Oxbryta 500 mg tablets? If **YES,** please answer question to the right.	☐ Yes	☐ No	Is the member 12 years of age or older?	☐ Yes	☐ No
Is the request for Oxbryta 300 mg tablets OR Oxbryta 300 mg tablets for suspension? If **YES,** please answer question to the right.	☐ Yes	☐ No	Is the member 4 years of age or older?	☐ Yes	☐ No
Additional information the prescribing provider feels is important to this review. Please specify below or submit medical records.					

Signature affirms that information given on this form is true and accurate and reflects office notes.

Prescribing Provider's Signature: _____ **Date:** _____

Please note: Incomplete forms or forms without the chart notes will be returned

Office notes, labs, and medical testing relevant to the request that show medical justification are required.

Standard turnaround time is 24 hours. You can call 855-300-5528 to check the status of a request.