MOLINA HEALTHCARE
Service Authorization (SA) Form
SICKLE CELL DISEASE DRUGS

If the following information is not complete, correct, or legible, the SA process can be delayed.
Please use one form per member. **Preferred drugs Droxia® and Endari® do not require a SA**

MEMBER INFORMATION

Last Name:

First Name:

Medicaid ID Number:

Date of Birth: ___ – ___ – ____

Gender: ☐ **Male** ☐ **Female**

Weight in Kilograms: _____

PRESCRIBER INFORMATION

Last Name:

First Name:

NPI Number:

Phone Number: ___ – ___ – ____

Fax Number: ___ – ___ – ____

DRUG INFORMATION

Drug Name/Form: _____

Strength: _____

Dosing Frequency: _____

Length of Therapy: _____

Quantity per Day: _____

See below for drugs requiring SA:

☐ Adakveo® ☐ Siklos®

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

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VA-ALL-PF-18305-24

Member's Last Name: | | | | | | | | | | | | |

Member's First Name: | | | | | | | | | | | | |

2. Does the patient have a diagnosis of Sickle Cell Disease presenting as one of following (HbSS, HbSC, HbSβ^{o}-thalassemia, or HbSβ^{+}-thalassemia)? AND ☐ Yes ☐ No
3. Is the medication dose proper for the patient's age or other conditions affecting the dose, according to the product package insert approved by the FDA? ☐ Yes ☐ No

*** For Adakveo®,**

4. Has the patient had an insufficient response to a minimum 3-month trial of hydroxyurea (unless contraindicated or intolerant)? ☐ Yes ☐ No
5. Patient has experienced TWO or more vaso-occlusive crises (VOC) in the previous year despite adherence to hydroxyurea therapy? AND ☐ Yes ☐ No

**** Siklos® (hydroxyurea)**

6. Is the member between 2 to 17 years of age ☐ Yes ☐ No

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 SA process.
Submission of documentation does NOT guarantee coverage by Molina Healthcare.

The completed form may be **FAXED to 1-844-278-5731**, or you may call **(800) 424-4518 (TTY: 711)**.

Molinahealthcare.com