pennsylvania
DEPARTMENT OF HUMAN SERVICES

Office of Medical Assistance Programs
Fee-for-Service, Pharmacy Division
Phone 1-800-537-8862 Fax 1-866-327-0191

SICKLE CELL ANEMIA AGENTS PRIOR AUTHORIZATION FORM

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:		Suite #:	City/State/Zip:
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Non-preferred 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.*
INITIAL requests		
Does the beneficiary have a history of therapeutic failure of maximum tolerated doses of **hydroxyurea** for a period of at least 6 months?	☐Yes ☐No	*Submit documentation.*
Does the beneficiary have a contraindication or intolerance to hydroxyurea?	☐Yes ☐No	*Submit documentation.*
RENEWAL requests		
Has the beneficiary experienced a positive clinical response to the requested medication?	☐Yes ☐No	*Submit documentation.*

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

Prescriber Signature:	Date:

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