



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>.

<input type="checkbox"/> New request	<input type="checkbox"/> 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 (<i>submit documentation</i>):		Dx code (<i>required</i>):	
Is the medication being prescribed by or in consultation with a hematologist/oncologist or sickle cell disease specialist?		<input type="checkbox"/> Yes	<i>Submit documentation of consultation, if applicable.</i>
		<input type="checkbox"/> No	

**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 DHS – PHARMACY DIVISION

Prescriber Signature:

Date:

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