

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

Geisinger Health Plan’s website at

<https://healthplan.geisinger.org/pharmacy/pharmacy.aspx?strip=true&style=OneGeisinger>.

<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 (submit documentation):		DX code (required):	
Is the medication being prescribed by or in consultation with a hematologist/oncologist or sickle cell disease specialist?		<input type="checkbox"/> Yes Submit documentation of consultation, if applicable. <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 submit to PromptPA <https://ghp.promptpa.com> OR fax to Geisinger Health Plan at 570-271-5610 the completed form with required clinical documentation.

Prescriber Signature:

Date:

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