Member Name: ______________________________ Member ID: ________________ Member DOB: ________________

Drug Name: _____________________________ Strength: _______________ Directions: _______________________________________

Physician Name: __________________________ Physician Phone #: _________________________ Specialty: ______________________

Physician Fax #: _____________________ Pharmacy Name: ____________________________Pharmacy Phone: __________________

Horizon NJ Health

Voxelotor (Oxbryta) – *Medical Necessity Request*

*****Complete page 1 for Initial Requests Only*****

Diagnosis Information (please indicate the diagnosis and answer the related questions):

□ **Sickle Cell Disease**

1. What is the member's current hemoglobin (Hgb) level in g/dL? _______________________________

   ***Please submit documentation from within the past 30 days.**

□ **Other:** _
____

Physician office's signature*_______________________________ Print Name______________________________

***Form must be completed and signed by physician or licensed representative from the physician's office**

Member Name: ______________________________ Member ID: ________________ Member DOB: ________________

Drug Name: _____________________________ Strength: _______________ Directions: ______________________________________

Physician Name: __________________________ Physician Phone #: _________________________ Specialty: ______________________

Physician Fax #: _____________________ Pharmacy Name: ____________________________Pharmacy Phone: __________________

Horizon NJ Health

Voxelotor (Oxbryta) – *Medical Necessity Request*

*****Complete page 2 only for Subsequent/Renewal requests*****

1. Has the member had an increase in hemoglobin (Hgb) by at least 1 g/dL compared to baseline?
   □ Yes
   □ No

2. What is the member's current Hgb level in g/dL? ______________________________
   ***Please submit documentation from within the past 60 days.**

Physician office's signature*________________________________ Print Name_______________________________

***Form must be completed and signed by physician or licensed representative from the physician's office**