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**