Excellus

Adakveo® crizanlizumab-tmca
for
Management of Sickle Cell Disease (SCD)
Medical Benefit

Specialty Medication Review Program

Complete and fax this form to:

Medical Review Unit
Fax: 1-800-306-0188
Phone: 1-800-499-1275

If not **buying and billing** medication, please indicate specialty pharmacy below:

☐ **Accredo Health**
Fax: 1-888-773-7386
Phone #: 1-866-413-4137

☐ **AllianceRx Walgreens Pharmacy**
Fax: 1-866-435-2173
Phone: 1-866-435-2171

Complete ALL the following Patient/Prescriber Information: (Please Print)

Patient Information	
Patient Name:	Patient Phone #: ( )
Patient ID #	Patient Birthdate:
List Patient Allergy (If Any)	
Prescriber Information	
Prescriber Name:	Prescriber Specialty:
Prescriber Address:	
Prescriber Phone #:	Prescriber Fax #:
Prescriber NPI #:	Office Contact: Extension:

Location of Infusion:
☐ **Prescriber office** ☐ **Home/Homecare agency:**_____
☐ **Outpatient facility:** ☐ **Other:** _____

Servicing Prescriber NPI (if different from the ordering prescriber):

Provide address of infusion location above for medication shipping:

Medication/Medical and Dispensing Information

Medication	Dose	Frequency	Height	Weight (lbs./kg)	Procedure Code
Adakveo (J0791)	10mg/ml	5 mg/kg IV Week 0, 2, and every 4 weeks thereafter			

List any other medications which will used in combination with Adakveo:
1. _____ 2. _____ 3. _____

Diagnosis/ICD-10: _____

Is this request for a: ☐ New Start ***OR*** ☐ Continuation of Therapy (Recertification) Start date: _____

Questions/Indications for Medical Necessity

**** See the Sickle Cell Disease Management Policy (Pharmacy-84) for full Prior Authorization criteria ****
Submit patient progress notes with all requests and provide any details regarding sample medications given, including date and quantity supplied. For **re-certification** requests, submit documentation of subjective/objective assessment of response to medication (e.g., reduction in number and/or severity (ex. fewer/shorter hospitalizations) of VOCs compared to baseline.

1. Does this patient have a *confirmed* diagnosis of Sickle Cell Disease (SCD)? Provide diagnosis: _____	☐ Yes ☐ No
2. Is The Prescriber A: ☐ Hematologist ☐ Prescriber who specializes in SCD ☐ Other_____	☐ Yes ☐ No
3. Has this patient had **≥1 vaso-occlusive event(s)** (VOCs; ex. acute pain caused by a VOC, acute chest syndrome, hepatic or splenic sequestration, priapism) **requiring a medical facility visit** (Emergency room, hospital admission, clinic, unscheduled physician visit) **within the last 12 months?** ***Indicate the number of VOCs within the last 12 months (to be used as baseline):** _____ ****Provide progress notes to document the date and nature of interventions.**	☐ Yes ☐ No
Hydroxyurea	
1. Has this patient had a minimum 6-month trial of hydroxyurea? *If NO, proceed to question # 2. *If YES, please explain: _____, then proceed to question # 3	☐ Yes ☐ No
2. Has this patient had 2 hematologic toxicity reactions that caused hydroxyurea to be discontinued? *If YES: please explain: _____	☐ Yes ☐ No
3. Does this patient have a contraindication to hydroxyurea? *If YES, please explain: _____	☐ Yes ☐ No

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Indicate any current & previous treatments			
Drug Name	Strength & Dosing	Period of use	Outcomes
		Start: End:	
		Start: End:	
		Start: End:	
Provide Other Comments/Clinical Justification:			

ATTACH CLINICAL NOTES RELATED TO THIS REQUEST. IF DOCUMENTATION IS NOT PROVIDED, IT MAY DELAY THE REQUEST.

*Prescriber Signature: _____ Date: _____
I certify the above is true and accurate to the best of my knowledge.