ATRIO HEALTH PLANS

Sickle Cell Disease
Adakveo (crizanlizumab-tmca) J0791
Prior Authorization Request
Medicare Part B Form

*Instructions: * Indicates required information – Form may be returned if required information is not provided. Please fax this request to the appropriate fax number listed at the bottom of the page.*

☐	**Standard Request– (72 Hours)**	☐	**Urgent Request** (standard time frame could place the member's life, health or ability in serious jeopardy)
	Date Requested _____		
	Requestor _____ Clinic name: _____ Phone / Fax		

MEMBER INFORMATION

*Name:_____ *ID#:_____ *DOB:_____

PRESCRIBER INFORMATION

*Name:_____ ☐MD ☐FNP ☐DO ☐NP ☐PA *Phone:_____

*Address:_____ *Fax:_____

DISPENSING PROVIDER / ADMINISTRATION INFORMATION

*Name:_____ Phone:_____

*Address:_____ Fax:_____

PROCEDURE / PRODUCT INFORMATION

HCPC Code	Name of Drug	Dose (Wt: _____ kg Ht:_____)	Frequency	End Date if known

☐ **Self-administered** ☐ **Provider-administered** ☐ **Home Infusion**

☐Chart notes attached. **Other important information:**_____

Diagnosis: ICD10: _____ **Description**: _____

☐ Provider attests the diagnosis provided is an FDA-Approved indication for this drug

☐ **New Start or Initial Request: (Clinical documentation required for all requests)**

- ☐ Patient has a diagnosis of sickle cell disease;
- ☐ Documentation is provided that Patient had at least two episodes of sickle cell related pain crises in the past 12 months;
- ☐ Patient is not using in combination with voxelotor (Oxbryta).

☐ **Continuation Requests: (Clinical documentation required for all requests)**

- ☐ Documentation is provided that Patient experienced a reduction in acute complications of sickle cell disease (e.g. reduction in the number of vaso-occlusive episodes, acute chest syndrome episodes) since initiation Adakveo.

ACKNOWLEDGEMENT

Request By (Signature Required): _____Date:_____ /____ /____

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. **THIS AUTHORIZATION IS NOT A GUARANTEE OF PAYMENT.** PAYMENT IS BASED ON BENEFITS IN EFFECT AT THE TIME OF SERVICE, MEMBER ELIGIBILITY AND MEDICAL NECESSITY.

For questions or assistance, please contact Customer Service at 1-877-672-8620, daily, 8am – 8pm (PST) (TTY users should call 1-800-735-2900).

Prior Authorization Group – Sickle Cell Disease Drug PA

Drug Name(s):
ADAKVEO **CRIZANLIZUMAB-TMCA**

Criteria for approval of Non-Formulary/Preferred Drug:

1. Prescribed for an approved FDA diagnosis (as listed below):
2. Member does not have any clinically relevant contraindications, or CMS/Plan exclusions, to the requested drug.

- If the member meets all these criteria, they may be approved by the Plan for the requested drug.
- Quantity limits and Tiering will be determined by the Plan.

Exclusion Criteria:
N/A

Prescriber Restrictions:
Hematologist or another related specialist

Coverage Duration:
Initial Approval will be for 6 months
Continuation will be approved for 12 months

FDA Indications:
Adakveo

- Sickle cell disease with crisis; Prophylaxis

Off-Label Uses:
N/A

Age Restrictions:
16 years and older.

Other Clinical Consideration:
N/A

Resources:
https://www.micromedexsolutions.com/micromedex2/librarian/CS/19FA6A/ND_PR/evidencexpert/ND_P/evidencexpert/DUPLICATIONSHIELDSYNC/D077B2/ND_PG/evidencexpert/ND_B/evidencexpert/ND_AppProduct/evidencexpert/ND_T/evidencexpert/PFActionId/evidencexpert.GoToDashboard?docId=932794&contentSetId=100&title=Crizanlizumab-tmca&servicesTitle=Crizanlizumab-tmca&brandName=Adakveo&UserMdxSearchTerm=Adakveo&=null#