Hy-Vee health INFUSION CARE

ADAKVEO (CRIZANLIZUMAB) Infusion Orders

PHONE 515.225.2930 | **FAX** 515.559.2495

Patient Information

Fax completed form, insurance information and clinical documentation to 515.559.2495.

Patient Name: _____ **DOB:** _____ **Phone:** _____

Patient Status: ☐ New to Therapy ☐ Continuing Therapy **Next Treatment Date:** _____

INSURANCE INFORMATION: Please attach a copy of insurance cards (front and back).

Medical Information

Diagnosis: ☐ Sickle cell disease

☐ Other _____

ICD-10 Code: _____

Patient Weight: _____ lbs. (required) **Allergies:** _____

Therapy Order

Adakveo:

☐ **Initial Start:** 5 mg/kg IV on weeks 0 and 2, then every 4 weeks thereafter x 1 year

☐ **Maintenance Dosing:** 5 mg/kg IV every 4 weeks x 1 year

Additional Orders: _____

Lab Orders: _____ **Lab Frequency:** _____

Anaphylactic Reaction Orders (home patients):

- Epinephrine (based on patient weight):
- >30 kg (>66lbs): EpiPen 0.3 mg or compounded syringe IM or subQ; may repeat in 5-10 minutes x1
- 15-30 kg (33-66lbs): EpiPen Jr. 0.15 mg or compounded syringe IM or subQ; may repeat in 5-10 minutes x1
- Diphenhydramine: Administer 25-50 mg PO or IV (adult)
- Refer to physician order or institutional protocol for pediatric dosing as applicable

Provider Information

By signing this form and utilizing our services, you are authorizing *Hy-Vee Health* and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies, and to select the preferred site of care for the patient.

Provider Name: _____ **Signature:** _____ **Date:** _____

Provider NPI: _____ **Phone:** _____ **Fax:** _____ **Contact Person:** _____

☐ Opt out of Hy-Vee Health selecting site of care (if checked, please list site of care): _____

Service Areas

☐ Des Moines, IA ☐ West Des Moines, IA ☐ Chicago, IL ☐ Omaha, NE ☐ Buffalo, NY ☐ Dallas, TX

☐ Phoenix, AZ ☐ Other _____

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COMPREHENSIVE SUPPORT FOR ADAKVEO THERAPY

Patient Information

Patient Name: _____ **DOB:** _____

Required Documentation for Referral Processing & Insurance Approval

☐ Include signed and completed order (MD/prescriber to complete page 1)

☐ Include patient demographic information and insurance information

☐ Include patient's medication list

☐ Supporting clinical notes (H&P) to support primary diagnosis – including:

- ☐ Does the patient have a history of 2 or more sickle cell-related vaso-occlusive crises within the previous 12 months?
  - ☐ Yes ☐ No
- ☐ Is the patient currently receiving hydroxyurea therapy?
  - ☐ Yes ☐ No
- ☐ Does the patient have a history of treatment failure, intolerance or contraindication to hydroxyurea therapy?
  - ☐ Yes ☐ No

☐ **Other Medical Necessity:** _____

Hy-Vee Health will complete insurance verification and submit all required documentation for approval to the patient's insurance company for eligibility. Our team will notify you if any additional information is required. We will review financial responsibility with the patient and refer him/her to any available co-pay assistance as needed. Thank you for the referral.

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