Fax completed form to: (855) 840-1678
If this is an URGENT request, please call (800) 882-4462
(800.88.CIGNA)

Adakveo
(crizanlizumab-tmca)

PHYSICIAN INFORMATION			PATIENT INFORMATION		
* Physician Name:			*Due to privacy regulations we will not be able to respond via fax with the outcome of our review unless all asterisked (*) items on this form are completed.*		
Specialty:	* DEA, NPI or TIN:				
Office Contact Person:			* Patient Name:		
Office Phone:			* Cigna ID:	* Date of Birth:	
Office Fax:			* Patient Street Address:		
Office Street Address:			City:	State:	Zip:
City:	State:	Zip:	Patient Phone:		

Urgency:
☐ Standard ☐ Urgent (In checking this box, I attest to the fact that applying the standard review time frame may seriously jeopardize the customer's life, health, or ability to regain maximum function)

Medication Requested: ☐ Adakveo 100mg/10ml vial ICD10:

Directions for use: Dose: Quantity: Duration of therapy:

Is this initial therapy or is the patient currently receiving Adakveo?
☐ Initial therapy
☐ Currently receiving Adakveo

((if currently receiving) Has the prescriber confirmed that the patient is receiving clinical benefit from Adakveo therapy? Note: Examples of clinical benefit include reduction in the number of vasoocclusive crises/sickle cell-related crises; delay in time to sickle cell-related crises; and reduction in the number of days in the hospital. ☐ Yes ☐ No

(if no) Please provide support for continued use.

Where will this medication be obtained?
☐ Option Care
☐ Hospital Outpatient
☐ Retail pharmacy
☐ Other (please specify):
☐ Home Health / Home Infusion vendor
☐ Physician's office stock (billing on a medical claim form)

Facility and/or doctor dispensing and administering medication:
Facility Name: State: Tax ID#:
Address (City, State, Zip Code):

Where will this drug be administered?
☐ Patient's Home
☐ Hospital Outpatient
☐ Physician's Office
☐ Other (please specify):

NOTE: *Per some Cigna plans, infusion of medication MUST occur in the least intensive, medically appropriate setting.*

Is this patient a candidate for re-direction to an alternate setting (such as alternate infusion site, physician's office, home) with assistance of a Specialty Care Options Case Manager? ☐ Yes ☐ No (provide medical necessity rationale):

Is the requested medication for a chronic or long-term condition for which the prescription medication may be necessary for the life of the patient? ☐ Yes ☐ No

Diagnosis:
☐ Sickle Cell Disease (SCD)
☐ Other (Please specify):

Clinical Information:

(if initial therapy) Has your patient had at least one sickle cell-related crisis in the previous 12-month period? Yes ☐ No ☐

(if initial therapy) Which of the following is true in regard to your patient taking hydroxyurea for Sickle Cell Disease?

☐ The patient is currently receiving a hydroxyurea product
☐ The patient tried hydroxyurea, but they had inadequate efficacy
☐ The patient tried hydroxyurea, but they had significant intolerance
☐ The patient cannot try hydroxyurea because they are not a candidate for it. Note: Examples include patients who are pregnant or who are planning to become pregnant and patients with an immunosuppressive condition (such as cancer)
☐ Other

Is Adakveo being prescribed by, or in consultation with, a physician who specializes in sickle cell disease (for example, a hematologist)? Yes ☐ No ☐

Additional pertinent information *(Please provide any additional pertinent clinical information, including: if the patient is currently on the requested drug (with dates of use) and how they have been receiving it (for example: samples, out of pocket).*

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan or insurer its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature:_____ **Date:**_____

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Our standard response time for prescription drug coverage requests is 5 business days. If your request is urgent, it is important that you call us to expedite the request. View our Prescription Drug List and Coverage Policies online at cigna.com.

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