



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: <input type="checkbox"/> Standard <input type="checkbox"/> 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: <input type="checkbox"/> Adakveo 100mg/10ml vial ICD10:					
Directions for use:		Dose:	Quantity:	Duration of therapy:	
Is this a new start or continuation of therapy***? <input type="checkbox"/> new start of therapy <input type="checkbox"/> continued therapy – Start date: ***If your patient has already begun treatment with drug samples of this drug, please choose "new start of therapy".					
(if continued therapy) Is there documentation that your patient has had a beneficial clinical response (for example, reduction in vasoocclusive crises, delay in time to sickle cell-related pain crises, reduction in the number of days in the hospital)? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Where will this medication be obtained? <input type="checkbox"/> Accredo Specialty Pharmacy** <input type="checkbox"/> Retail pharmacy <input type="checkbox"/> Prescriber's office stock (billing on a medical claim form) <input type="checkbox"/> Home Health / Home Infusion vendor <input type="checkbox"/> Other (please specify): **Cigna's nationally preferred specialty pharmacy					
**Medication orders can be placed with Accredo via E-prescribe - Accredo (1640 Century Center Pkwy, Memphis, TN 38134-8822 NCPDP 4436920), Fax 888.302.1028, or Verbal 866.759.1557					
Facility and/or doctor dispensing and administering medication:					
Facility Name:		State:	Tax ID#:		
Address (City, State, Zip Code):					
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? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Diagnosis: <input type="checkbox"/> Sickle Cell Disease (SCD) <input type="checkbox"/> Other (Please specify):					
Clinical Information: Will Adakveo be used concurrently with hydroxyurea? Yes <input type="checkbox"/> No <input type="checkbox"/> (if no) Has your patient tried hydroxyurea and had intolerance (for example, unacceptable toxicity)? Yes <input type="checkbox"/> No <input type="checkbox"/> (if no) Does your patient have a contraindication per FDA label to using hydroxyurea or is otherwise not a candidate for hydroxyurea (for example, patient who is planning to become pregnant; a pregnant patient; or a patient with an immunosuppressive condition [such as cancer])? Yes <input type="checkbox"/> No <input type="checkbox"/> (if yes) Please list the intolerance your patient experienced or the contraindication(s) that your patient has to hydroxyurea along with all the reasons your patient is not a candidate to use hydroxyurea. _____ While taking Adakveo, will your patient also use Oxbritya (voxelotor) during the same time period? <input type="checkbox"/> Yes or Possibly <input type="checkbox"/> No <input type="checkbox"/> Unknown (if yes) Please explain and provide clinical rationale for concurrent use of these drugs. _____					

Is Adakveo being prescribed by, or in consultation with, a hematologist or a physician who specializes in Sickle Cell Disease?

Yes ☐ No ☐

Has your patient had at least one vasoocclusive crises (VOC) in the past 12 months?

Yes ☐ No ☐

Additional pertinent information (including prior therapy, disease stage, performance status, and names/doses/admin schedule of any agents to be used concurrently):

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:** _____

Save Time! Submit Online at: www.covermymeds.com/main/prior-authorization-forms/cigna/ or via SureScripts in your EHR.

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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