



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 vasooclusive 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"/> Prescriber's office stock (billing on a medical claim form) <input type="checkbox"/> Other (please specify):			<input type="checkbox"/> Retail pharmacy <input type="checkbox"/> Home Health / Home Infusion vendor **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.covermy meds.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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