

Adakveo (crizanlizumab-tmca)

Provider Order Form rev. 1/2/2025



PATIENT INFORMATION

Referral Status: New Referral Updated Order Order Renewal

Patient Full Name: _____ DOB: _____ Phone: _____ Gender: M F Other

Email Address: _____ Address: _____ Weight (lbs/kg): _____ Height (in): _____

NKDA Allergies: _____ Existing prior authorization? Yes, (Send a copy) No (AIC will process)

Patient Status: New to Therapy Continuing Therapy Last Treatment Date: _____ Next Due Date: _____

Patient Preferred Location:

DIAGNOSIS & CLINICAL INFORMATION

ICD 10-Code & Description (Provide full completed code)

D57.1 Sickle cell disease without crisis
 D57.3 Sickle Cell Trait
 D57.40 Sickle cell thalassemia with crisis

D57.80 Other sickle cell disorders without crisis
 D57.81 Other sickle cell disorders with crisis
 Other: _____

REQUIRED DOCUMENTATION: Please include insurance card (front & back), all patient demographics, history & physicals, medication lists, recent lab results (CBC, CMP, TB, Hep B panel-depending on medication) , signed prescription order and recent visit notes.

Confirm that these and the required lab orders have been sent to American Infusion Care and necessary parties.

PRESCRIPTION INFORMATION

Nursing: Provide nursing care per American Infusion Care - Specialty Infusions protocols, including reaction management and post-procedure observation

Pre-Medications

Acetaminophen (Tylenol) 500mg 650mg 1000mgPO
 Cetirizine (Zyrtec) 10mgPO
 Loratadine (Claritin) 10mgPO
 Diphenhydramine (Benadryl) 25mg 50mg PO IV
 Methylprednisolone (Solu-Medrol) 40mg 125mg IV
 Other: _____ Dose: _____ Route: _____

Lab Orders

Required: Tried & Failed Hydroxyurea Y N

of VOC's in previous 12 months _____

Other: _____

Adakveo (crizanlizumab-tmca) IV:

Infuse over 30 minutes with a 0.2 micron filter in 100mL of 0.9% sodium chloride, intravenous infusion

Route: Intravenous

Loading Dose:

Infuse 5 mg/kg at week 0, 2, and every 4 weeks thereafter other: _____

Maintenance Dose:

Infuse 5 mg/kg every 4 weeks other: _____

Post Treatment Observations: The patient is required to stay for 30 minutes following the first administration.

Special Instructions: _____

Refills: zero for 12 months _____ (Prescription valid for one year, unless otherwise indicated)

PROVIDER INFORMATION

Provider Full Name: _____ Provider NPI #: _____ Specialty: _____

Practice Address: _____ City: _____ State: _____ Zip Code: _____

Contact Name: _____ Phone: _____ Fax: _____ Email: _____

Provider Name (Print)

Provider Signature

Date