

## ADAKVEO MEDICATION ORDER

Patient's Name (Last, First, Middle) \_\_\_\_\_

DOB: \_\_\_\_\_

*Pt must be age 16+*

■ **Diagnosis** *Select the most specific code. If there is a blank, the code must be completed.*

- |  |  |
|--|--|
| <input type="checkbox"/> D57.03 Hb-SS with cerebral vascular involvement       | <input type="checkbox"/> D57.43 Sickle-cell thalassemia beta zero w/ _____     |
| <input type="checkbox"/> D57.09 Hb-SS with crisis other specified complication | <input type="checkbox"/> D57.44 Sickle-cell thalassemia beta+ w/o crisis       |
| <input type="checkbox"/> D57.213 Sickle-cell/Hb-C with cerebro-vasc involv     | <input type="checkbox"/> D57.45 Sickle-cell thalassemia beta+ w/ _____         |
| <input type="checkbox"/> D57.218 Sickle-cell/Hb-C w/crisis w/other spec compl  | <input type="checkbox"/> D57.813 Other sickle-cell with CV involv              |
| <input type="checkbox"/> D57.41 Sickle-cell thalassemia unspec w/ _____        | <input type="checkbox"/> D57.818 Other sickle-cell w/crisis w/other spec compl |
| <input type="checkbox"/> D57.42 Sickle-cell thalassemia beta zero w/o crisis   |  |

■ **Details Needed for Authorization** *Please answer all questions, and provide supporting documentation.*

- Does the patient have significant qty of HbS w/ or w/o add'l abnormal  $\beta$ -globin chain variant by hemoglobin assay? \_\_\_\_\_
- Does the patient have biallelic HBB pathogenic variants where at least 1 allele is the p.Glu6Val pathogenic variant on molecular genetic testing? \_\_\_\_\_
- Has the patient had at least 1 sickle cell crisis within the preceding 12 months which includes receipt of pain medication? \_\_\_\_\_
- Has the patient tried and failed on generic hydroxyurea? \_\_\_\_\_
- If the patient is on concomitant hydroxyurea, was it started at least 6 months ago, and stable for at least 3 months? \_\_\_\_\_
- If the patient is on concomitant erythropoetin, was it started at least 6 months ago, and stable for at least 3 months? \_\_\_\_\_
- Is the patient on concomitant Oxbritya (voxelotor) tablets? \_\_\_\_\_
- Is the patient on concomitant Endari (L-glutamine oral powder)? \_\_\_\_\_

■ **Adakveo (crizanlizumab-tmca) Medication Order** Patient's height in ft/in: \_\_\_\_\_ Patient's weight in lbs: \_\_\_\_\_

- Initial dose: 5 mg/kg by IV over a period of 30 minutes at weeks 0 and 2
- Maintenance dose: 5 mg/kg by IV over a period of 30 minutes every 4 weeks for \_\_\_\_\_ months.

*Medication shall be brought to room temperature over 4 hours. Do not shake the vials. Inject the appropriate dose to a 100ml 0.9% NaCl infusion bag. Gently invert the bag to mix, do not shake. The IV line shall have a 0.2 or 0.22 micron in-line filter attached. Post infusion flush with normal saline. Check vitals and monitor for signs and symptoms at start, throughout infusion, and after completion.*

■ **Rescue Management in case of Infusion Therapy Reaction**

*These include fever, chills, rigors, headache, rash, itching, swelling, edema, nausea, vomiting, abdominal pain, hypotension, and respiratory distress.*

- Stop medication infusion and start normal saline infusion at 50 ml/hr. Call ordering provider to report reaction.
- Follow standing reaction orders, including diphenhydramine, methylprednisolone, albuterol and oxygen as needed. Exercise caution with corticosteroids in patients with sickle cell disease unless clinically indicated.
- For severe reactions, administer Epi-pen or equivalent and call 911. Repeat if severe symptoms persist.

■ **Ordering Provider Authorization**

Provider's Signature: \_\_\_\_\_ Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ NPI #: \_\_\_\_\_ License: \_\_\_\_\_

Best Contact Person in Office: \_\_\_\_\_ Direct Phone Line to Contact Person: \_\_\_\_\_

**STANDARD DOCUMENTATION TO INCLUDE:**

- Patient demographics and insurance, including card scans (both medical and pharmacy benefit cards, both sides).
- Most recent chart notes and, if available, last history and physical. All relevant scans, tests and laboratory results.
- If new medication for patient, chart notes which include decision to begin treatment. If not, provide last treatment date.

**Fax this order and supporting documentation to (732) 329-2322.**