Updated: 12/2019
PARP Approved: 02/2020

Prior Authorization Criteria

Adakveo (crizanlizumab)

All requests for Brand Name (generic name) require a prior authorization and will be screened for medical necessity and appropriateness using the criteria listed below.

Coverage may be provided with a diagnosis of Sickle Cell Disease and the following criteria is met:

- Member must be 16 years of age or older.
- Diagnosis is confirmed by electrophoresis demonstrating the presence of sickle cell disease (HbSS, HbSC, HbSβ^0-thalassemia, or HbSβ^+-thalassemia).
- Member must have a hemoglobin $\geq$ 4.0 g/dL
- Must be prescribed by or in association with hematologist/oncologist or sickle cell disease specialist.
- Must provide documentation showing the member has tried and failed (which will be verified via pharmacy claims if available) or had an intolerance or contraindication to at least a 6 month trial of hydroxyurea.
- Member must have had at least 2 vaso-occlusive crises in the past 12 months.
- Member must not be on a chronic transfusion program or planning on exchange transfusion while on medication.
- Member must not be receiving chronic anticoagulation therapy (e.g. warfarin, heparin) other than aspirin.
- The requested dose and frequency is in accordance with FDA-approved labeling, nationally recognized compendia, and/or evidence-based practice guidelines
- **Initial Duration of Approval:** 12 months
- **Reauthorization criteria**
    - There must be clinical documentation that there has been a reduction in vaso-occlusive events since initiating therapy.
- **Reauthorization Duration of Approval:** 12 months

Coverage may be provided for any non-FDA labeled indication if it is determined that the use is a medically accepted indication supported by nationally recognized pharmacy compendia or peer-reviewed medical literature for treatment of the diagnosis(es) for which it is prescribed. These requests will be reviewed on a case by case basis to determine medical necessity.

When criteria are not met, the request will be forwarded to a Medical Director for review. The physician reviewer must override criteria when, in their professional judgment, the requested medication is medically necessary.

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ADAKVEO
PRIOR AUTHORIZATION FORM

Please complete and fax all requested information below including any progress notes, laboratory test results, or chart documentation as applicable to Gateway Health℠ Pharmacy Services. **FAX:** (888) 245-2049
If needed, you may call to speak to a Pharmacy Services Representative.
PHONE: (800) 392-1147 Monday through Friday 8:30am to 5:00pm

PROVIDER INFORMATION

Requesting Provider:	NPI:
Provider Specialty:	Office Contact:
Office Address:	Office Phone:
	Office Fax:

MEMBER INFORMATION

Member Name:	DOB:
Gateway ID:	Member weight: _____pounds or _____kg

REQUESTED DRUG INFORMATION

Medication:	Strength:
Frequency:	Duration:
Is the member currently receiving requested medication? ☐ Yes ☐ No	Date Medication Initiated:

Billing Information

This medication will be billed: ☐ at a pharmacy **OR**
☐ medically (if medically please provide a JCODE:_____

Place of Service: ☐ Hospital ☐ Provider's office ☐ Member's home ☐ Other

Place of Service Information

Name:	NPI:
Address:	Phone:

MEDICAL HISTORY (Complete for ALL requests)

- Has the diagnosis been confirmed by electrophoresis demonstrating the presence of sickle cell disease (HbSS, HbSC, HbSβ⁰-thalassemia, or HbSβ⁺-thalassemia)?
  ☐ Yes ☐ No
- Does the member have a hemoglobin ≥ 4.0 g/dL?
  ☐ Yes ☐ No
- Is the medication being prescribed by or in association with hematologist/oncologist or sickle cell disease specialist?
  ☐ Yes ☐ No
- Has the member tried and failed or had an intolerance or contraindication to a 6 month trial of hydroxyurea?
  ☐ Yes ☐ No
- Has the member had between 2 and 10 vaso-occlusive crises in the past 12 months?
  ☐ Yes ☐ No
- Is the member on a chronic transfusion program or planning on exchange transfusion while on medication?
  ☐ Yes ☐ No
- Is the member receiving chronic anticoagulation therapy (e.g. warfarin, heparin) other than aspirin?
  ☐ Yes ☐ No

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CURRENT or PREVIOUS THERAPY			
Medication Name	**Strength/ Frequency**	**Dates of Therapy**	**Status (Discontinued & Why/Current)**

REAUTHORIZATION

Has the member experienced a reduction in vaso-occlusive events? ☐ Yes ☐ No

Please describe:

SUPPORTING INFORMATION or CLINICAL RATIONALE

Prescribing Provider Signature	Date