Updated: 11/2019
DMMA Approved: 12/2019

Request for Prior Authorization for Advakeo (crizanlizumab-tmca)
Website Form – www.highmarkhealthoptions.com
Submit request via: Fax - 1-855-476-4158

All requests for Adakveo (crizanlizumab-tmca) require a Prior Authorization and will be screened for medical necessity and appropriateness using the criteria listed below.

Adakveo (crizanlizumab-tmca) Prior Authorization Criteria:

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.
- **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.

Drugs are authorized in generic form unless the branded product is on the preferred drug list or the prescriber has indicated in writing that the branded product is medically necessary. If only the branded product is on the preferred drug list, the generic form will be considered non-preferred and shall not require the prescriber to indicate in writing that the branded product is medically necessary.

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Adakveo (crizanlizumab-tmca)
PRIOR AUTHORIZATION FORM

Please complete and fax all requested information below including any progress notes, laboratory test results, or chart documentation as applicable to Highmark Health Options Pharmacy Services. **FAX:** (855) 476-4158
If needed, you may call to speak to a Pharmacy Services Representative.
PHONE: (844) 325-6251 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:
Health Options 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:

Is this medication being used for a chronic or long-term condition for which the medication may be necessary for the life of the patient? ☐ Yes ☐ No

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, HbSβ^0-thalassemia, or HbSβ^+-thalassemia)?
  ☐ Yes ☐ No
- Does the member have a hemoglobin $\geq$ 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

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