Cigna®

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:
☐ Standard ☐ 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: ☐ Adakveo 100mg/10ml vial ICD10:

Directions for use: Dose: Quantity: Duration of therapy:

Where will this medication be obtained?
☐ Option Care
☐ Hospital Outpatient
☐ Retail pharmacy
☐ Other (please specify):
☐ Home Health / Home Infusion vendor
☐ Physician's office stock (billing on a medical claim form)

Facility and/or doctor dispensing and administering medication:
Facility Name: State: Tax ID#:
Address (City, State, Zip Code):

Where will this drug be administered?
☐ Patient's Home
☐ Hospital Outpatient
☐ Physician's Office
☐ Other (please specify):

NOTE: *Per some Cigna plans, infusion of medication MUST occur in the least intensive, medically appropriate setting.*

Is this patient a candidate for re-direction to an alternate setting (such as alternate infusion site, physician's office, home) with assistance of a Specialty Care Options Case Manager? ☐ Yes ☐ No (provide medical necessity rationale):

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? ☐ Yes ☐ No

Diagnosis:
☐ Sickle Cell Disease (SCD)
☐ All Others

Clinical Information:

Is the medication being prescribed by or in consultation with a physician who specializes in sickle cell disease (for example, a hematologist)? ☐ Yes ☐ No

Is the patient currently receiving Adakveo? ☐ Yes ☐ No

(if no) Has the patient had at least one sickle cell-related crisis in the previous 12-month period? ☐ Yes ☐ No

Is the patient currently receiving a hydroxyurea product? ☐ Yes ☐ No

(if no) According to the prescriber, has the patient tried a hydroxyurea product and experienced inadequate efficacy or significant intolerance? ☐ Yes ☐ No

(if no) According to the prescriber, is the patient a candidate for hydroxyurea therapy? Please Note: Examples of patients who are not candidates for hydroxyurea therapy include patients who are pregnant or who are planning to become pregnant and patients with an immunosuppressive condition (such as cancer). ☐ Yes ☐ No

(if currently receiving) According to the prescriber, is the patient receiving clinical benefit from Adakveo therapy? Please Note: Examples of clinical benefit include reduction in the number of vaso-occlusive crises/sickle cell-related crises, delay in time to sickle cell-related crises, and reduction in the number of days in the hospital. ☐ Yes ☐ No

Is the requested dosing for up to 5 mg/kg given by intravenous infusion at Weeks 0 and 2, and up to once every 4 weeks thereafter? ☐ Yes ☐ No

Additional pertinent information:

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:**_____

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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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