

HEALTHY U CHIP

PRIOR AUTHORIZATION REQUEST FORM

ADAKVEO®

For authorization, please answer each question and fax this form PLUS chart notes back to the Healthy U CHIP Prior Authorization Department at 801-213-1547.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance: 833-981-0212

Disclaimer: Prior authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:	HCPCS Code:	

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Product being requested: Adakveo® (crizanlizumab-tcma)

Dosing/Frequency: _____

If the request is for reauthorization, proceed to reauthorization section.

Questions	Yes	No	Comments/Notes
1. Does the member have a diagnosis of sickle cell disease?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
2. Does the member have a genotype of homozygous hemoglobin S, hemoglobin S β^0 -thalassemia, hemoglobin S β^* -thalassemia, or hemoglobin SC?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
3. Is the prescribing provider a hematologist/oncologist or sickle cell disease specialist?	<input type="checkbox"/>	<input type="checkbox"/>	
4. Is the member 16 years of age or older?	<input type="checkbox"/>	<input type="checkbox"/>	
5. Is the member's hemoglobin level $\geq 4\text{g/dL}$?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
6. Has the member experienced at least 2 vasoocclusive crises (VOC) in the past 6 months while on hydroxyurea at the maximum tolerated FDA-approved dose?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
7. Does the member have an intolerance or contraindication to hydroxyurea and has experienced at least 2 VOC in the past 12 months?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
8. Is the member unresponsive to L-glutamine?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
9. Does documentation include baseline incidences of VOC over the last 12 months?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
10. Have preventative measures been discussed with the member including regular clinic visits, healthy diet and folic acid supplements, adequate hydration, avoiding extreme temperatures, and smoking cessation?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation

11. Will Adakveo® be used concurrently with Oxbryta (voxelotor)?	<input type="checkbox"/>	<input type="checkbox"/>	
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Has the member had a positive response shown by an improvement in the incidence of VOC from baseline?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
3. Has the member been consistently taking hydroxyurea, unless contraindicated or intolerant?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.			
Additional information:			
Physician Signature:			

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Policy PHARM-CHIP-M049
 Origination Date: 04/20/2020
 Reviewed/Revised Date: 11/13/2024
 Next Review Date: 11/13/2025
 Current Effective Date: 12/01/2024

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