HEALTH PLANS
UNIVERSITY OF UTAH

PRIOR AUTHORIZATION REQUEST FORM
ADAKVEO®

For authorization, please answer each question and fax this form PLUS chart notes back to the U of U Health Plans 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 medical pharmacy prior authorization questions, please call for assistance: Individual Exchange: 833-981-0214, Commercial Groups: 833-981-0213, U of U Health Employee Plan 833-443-3440

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?	☐	☐	**Please provide documentation**
2. Does the member have a genotype of homozygous hemoglobin S, hemoglobin Sβ^0-thalassemia, hemoglobin Sβ*-thalassemia, or hemoglobin SC?	☐	☐	**Please provide documentation**
3. Is the prescribing provider a hematologist/oncologist or sickle cell disease specialist?	☐	☐	
4. Is the member 16 years of age or older?	☐	☐	
5. Is the member's hemoglobin level ≥4g/dL?	☐	☐	**Please provide documentation**
6. Has the member experienced at least 2 vasoocculsive crises (VOC) in the past 6 months while on hydoxyurea at the maximum tolerated FDA-approved dose?	☐	☐	**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?	☐	☐	**Please provide documentation**
8. Is the member unresponsive to L-glutamine?	☐	☐	**Please provide documentation**
9. Does documentation include baseline incidences of VOC over the last 12 months?	☐	☐	**Please provide documentation**
10. Have preventative measures been discussed with the member including regular clinic visits, healthy diet and folic acid	☐	☐	**Please provide documentation**

supplements, adequate hydration, avoiding extreme temperatures, and smoking cessation?			
11. Will Adakveo® be used concurrently with Oxbryta (voxelotor)?	☐	☐	
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Has the member had a positive response shown by an improvement in the incidence of VOC from baseline?	☐	☐	**Please provide documentation**
3. Has the member been consistently taking hydroxyurea, unless contraindicated or intolerant?	☐	☐	**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:			

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

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