**BIOCARE INFUSION**
**ONCOLOGY & THERAPEUTICS**

# ADAKVEO (CRIZANLIZUMAB)
## INFUSION ORDERS

**FAX:** 470.922.3656 | **PHONE:** 470.377.6400

## PATIENT INFORMATION:
Fax completed form, insurance information, and clinical documentation to 470.922.3656

Patient Name: _____ DOB: _____ Phone: _____

**Patient Status:** ☐ New to Therapy ☐ Continuing Therapy **Next Treatment Date:**

## INSURANCE INFORMATION:
Please attach a copy of insurance cards (front and back)

## MEDICAL INFORMATION

**Diagnosis:** ☐ Sickle cell disease
☐ Other: _____

**ICD-10 code:** _____

Patient Weight: _____ lbs. (required) Allergies: _____

## THERAPY ORDER

**Adakveo:**

☐ **Initial start:** 5mg/kg IV on week 0 and 2, then every 4 weeks thereafter x 1 year

☐ **Maintenance Dosing:** 5mg/kg IV every 4 weeks x 1 year

**Additional orders:** _____

**Lab orders:** _____ **Lab frequency:** _____

Anaphylactic Reaction Orders (home patients):

- Epinephrine (based on patient weight):
- >30kg (>66lbs): EpiPen 0.3mg or compounded syringe IM or subQ; may repeat in 5-10 minutes x1
- 15-30kg (33-66lbs): EpiPen Jr. 0.15mg or compounded syringe IM or subQ; may repeat in 5-10 minutes x1
- Diphenhydramine: Administer 25-50mg PO or IV (adult)
- Refer to physician order or institutional protocol for pediatric dosing as applicable

## PROVIDER INFORMATION

By signing this form and utilizing our services, you are authorizing *Biocare Infusion*, and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies, and to select the preferred site of care for the patient.

Provider Name: _____ Signature: Date: _____

Provider NPI: _____ Phone: _____ Fax: _____ Contact Person: _____

☐ Opt out of Biocare Infusion selecting site of care (if checked, please list site of care):

## PREFERRED LOCATION

City: _____ State: _____ *View our locations here:*

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# COMPREHENSIVE SUPPORT FOR ADAKVEO THERAPY

## PATIENT INFORMATION:

Patient Name: _____ DOB: _____

## REQUIRED DOCUMENTATION FOR REFERRAL PROCESSING & INSURANCE APPROVAL

☐ Include signed and completed order (MD/prescriber to complete page 1)

☐ Include patient demographic information and insurance information

☐ Include patient's medication list

☐ Supporting clinical notes (H&P) to support primary diagnosis - Including:

☐ Does the patient have a history of 2 or more sickle cell-related vaso-occlusive crises within the previous 12 months? ☐ Yes ☐ No

☐ Is the patient currently receiving hydroxyurea therapy?

☐ Does the patient have a history of treatment failure, intolerance, or contraindication to hydroxyurea therapy? ☐ Yes ☐ No

☐ Other medical necessity: _____

Biocare Infusion will complete insurance verification and submit all required documentation for approval to the patient's insurance company for eligibility. Our team will notify you if any additional information is required. We will review financial responsibility with the patient and refer him/her to any available co-pay assistance as needed. Thank you for the referral.

**Please fax all information to (470) 922-3656 or call (470) 377-6400 for assistance**