



# ADAKVEO® (crizanlizumab) Medication Precertification Request

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(All fields must be completed and legible for precertification review.)

Aetna Precertification Notification

Phone: 1-866-752-7021

FAX: 1-888-267-3277

For Medicare Advantage Part B:

Please Use Medicare Request Form

Please indicate: ☐ Start of treatment: Start date \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
☐ Continuation of therapy, Date of last treatment \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Precertification Requested By: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

## A. PATIENT INFORMATION

First Name:		Last Name:		DOB:	
Address:		City:		State:	ZIP:
Home Phone:	Work Phone:	Cell Phone:		Email:	
Patient Current Weight: ____ lbs or ____ kgs		Patient Height: ____ inches or ____ cms		Allergies:	

## B. INSURANCE INFORMATION

Aetna Member ID #: _____		Does patient have other coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Group #: _____		If yes, provide ID#: _____ Carrier Name: _____	
Insured: _____		Insured: _____	
Medicare: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide ID #: _____		Medicaid: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide ID #: _____	

## C. PRESCRIBER INFORMATION

First Name:		Last Name:		(Check One): <input type="checkbox"/> M.D. <input type="checkbox"/> D.O. <input type="checkbox"/> N.P. <input type="checkbox"/> P.A.	
Address:		City:		State:	ZIP:
Phone:	Fax:	St Lic #:	NPI #:	DEA #:	UPIN:
Provider Email:		Office Contact Name:		Phone:	
Specialty (Check one): <input type="checkbox"/> Hematologist <input type="checkbox"/> Other: _____					

## D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

<b>Place of Administration:</b> <input type="checkbox"/> Self-administered <input type="checkbox"/> Physician's Office <input type="checkbox"/> Outpatient Infusion Center Phone: _____ Center Name: _____ <input type="checkbox"/> Home Infusion Center Phone: _____ Agency Name: _____ <input type="checkbox"/> Administration code(s) (CPT): _____ Address: _____	<b>Dispensing Provider/Pharmacy: Patient Selected choice</b> <input type="checkbox"/> Physician's Office <input type="checkbox"/> Retail Pharmacy <input type="checkbox"/> Specialty Pharmacy <input type="checkbox"/> Other Name: _____ Address: _____ Phone: _____ Fax: _____ TIN: _____ PIN: _____
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## E. PRODUCT INFORMATION

Request is for: ADAKVEO (crizanlizumab) Dose: \_\_\_\_\_ Frequency: \_\_\_\_\_

## F. DIAGNOSIS INFORMATION - Please indicate primary ICD code and specify any other where applicable.

Primary ICD Code: \_\_\_\_\_ Secondary ICD Code: \_\_\_\_\_ Other ICD Code: \_\_\_\_\_

## G. CLINICAL INFORMATION - Required clinical information must be completed in its entirety for all precertification requests.

### For All Requests (clinical documentation required):

- ☐ Yes ☐ No Is this infusion request in an outpatient hospital setting?  
→ ☐ Yes ☐ No Has the patient experienced an adverse event with the requested product that has not responded to conventional interventions (e.g., acetaminophen, steroids, diphenhydramine, fluids, other pre-medications or slowing of infusion rate) or a severe adverse event (anaphylaxis, anaphylactoid reactions, myocardial infarction, thromboembolism, or seizures) during or immediately after an infusion?
- ☐ Yes ☐ No Does the patient have severe venous access issues that require the use of special interventions only available in the outpatient hospital setting?
- ☐ Yes ☐ No Does the patient have significant behavioral issues and/or physical or cognitive impairment that would impact the safety of the infusion therapy AND the patient does not have access to a caregiver?  
→ Please provide a description of the behavioral issue or impairment: \_\_\_\_\_
- ☐ Yes ☐ No Is the patient medically unstable which may include respiratory, cardiovascular, or renal conditions that may limit the member's ability to tolerate a large volume or load or predispose the member to a severe adverse event that cannot be managed in an alternate setting without appropriate medical personnel and equipment?  
→ Please provide a description of the condition: ☐ Cardiopulmonary: \_\_\_\_\_  
☐ Respiratory: \_\_\_\_\_  
☐ Renal: \_\_\_\_\_  
☐ Other: \_\_\_\_\_

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Patient First Name	Patient Last Name	Patient Phone	Patient DOB
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**G. CLINICAL INFORMATION (continued)** – Required clinical information must be completed in its entirety for all precertification requests.

- ☐ Yes ☐ No Does the patient have a documented diagnosis of sickle cell disease?
- ☐ Yes ☐ No Is the requested medication being requested for use in reducing the frequency of vasoocclusive crises (VOCs)?
- ☐ Yes ☐ No Is the requested medication being prescribed by or in consultation with a hematologist or specialist in sickle cell disease?

**For Initial Requests (clinical documentation required):**

Please indicate the sickle cell genotype:

- ☐ Homozygous hemoglobin S (HbSS) **or** ☐ Sickle beta0-thalassemia (HbSbeta0)

☐ Yes ☐ No Has the patient experienced, at any time in the past, an inadequate response or intolerance to a trial of hydroxyurea?

→ ☐ Yes ☐ No Does the patient have a contraindication to hydroxyurea?

→ ☐ Yes ☐ No Will the patient be using the requested medication with concurrent hydroxyurea therapy?

→ Please specify: ☐ Patient had an inadequate response ☐ Patient had an intolerance

- ☐ Sickle hemoglobin C (HbSC)

- ☐ Sickle beta+-thalassemia (HbSbeta+)

- ☐ Other/Unknown: \_\_\_\_\_

☐ Yes ☐ No Has the patient experienced a vasoocclusive crisis (VOC) in the past 12 months?

**For Continuation Requests (clinical documentation required):**

☐ Yes ☐ No Has the patient experienced a reduction in the frequency of vasoocclusive crises, or has the patient maintained a reduction in the frequency of vasoocclusive crises, since initiating therapy with the requested medication?

**H. ACKNOWLEDGEMENT**

**Request Completed By (Signature Required):** \_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

The plan may request additional information or clarification, if needed, to evaluate requests.