UTAH MEDICAID PHARMACY PRIOR AUTHORIZATION REQUEST FORM

Adakveo (crizanlizumab)

Member and Medication Information * indicates required field	
*Member ID:	*Member Name:
*DOB:	*Weight:
*Medication Name/ Strength:	
☐ Do Not Substitute. Authorizations will be processed for the preferred Generic/Brand equivalent unless specified.	
*Directions for use:	
Provider Information * indicates required field	
*Requesting Provider Name:	*Requesting Prescriber NPI:
Address:	
*Contact Person:	*Office Phone:
*Office Fax:	*Office Email:
Medically Billed Information * indicates required field for all medically billed products	
*Diagnosis Code:	*HCPCS Code:
*Dosing Frequency:	*HCPCS Units per Dose:
Servicing Provider Name:	NPI:
Servicing Provider Address:	
Facility/Clinic Name:	NPI:
Facility/Clinic Address:	
Fax form and relevant documentation including: laboratory results, chart notes and/or updated provider letter to Pharmacy PA at **855-828-4992**, to prevent processing delays.	

Criteria for Approval: (*All* of the following criteria must be met):

1. Is the patient 16 years of age or older? ❑ **Yes** ❑ **No**
2. Is the medication being prescribed by or in consultation with a hematologist specializing in the treatment of sickle cell disease? ❑ **Yes** ❑ **No**
3. Is the medication being used to reduce the frequency of vaso-occlusive crises associated with sickle cell disease? ❑ **Yes** ❑ **No**
4. Has the patient had 2 or more vaso-occlusive crises in the previous 12 months? ❑ **Yes** ❑ **No**
5. Does the patient continue to experience vaso-occlusive crises despite at least 4 months of therapy with a maximally tolerated dose of hydroxyurea? ❑ **Yes** ❑ **No**
6. Will the patient continue to use a maximally tolerated dose of hydroxyurea in combination with Adakveo?
7. Has the patient shown to be unresponsive to L-glutamine? ❑ **Yes** ❑ **No**

Reauthorization Criteria:

1. Has the patient experienced improvements in frequency of vaso-occlusive crises from baseline since starting the medication? ❑ **Yes** ❑ **No**

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Initial Authorization: Up to six (6) months
Reauthorization: Up to one (1) year

Note:

- ❖ Use appropriate HCPCS code for billing:
  Coverage and Reimbursement code lookup: https://health.utah.gov/stplan/lookup/CoverageLookup.php
  HCPCS NDC Crosswalk: https://health.utah.gov/stplan/lookup/FeeScheduleDownload.php

PROVIDER CERTIFICATION

I hereby certify this treatment is indicated, necessary and meets the guidelines for use.

______________________________________ _________________

Prescriber's Signature Date