

Referral Status:	MRN:
<input type="checkbox"/> New referral	<input type="checkbox"/> Order change
<input type="checkbox"/> Order Renewal	
Patient preferred clinic:	

# Adakveo® (crizanlizumab-tmca) Standard Plan of Treatment

Rev 4.25.25

## PATIENT DEMOGRAPHICS:

Patient's Name:	
Patient's Phone:	Address:
Date of Birth:	City, State, Zip:
Height in inches:	Weight: LB or KG Gender: Allergies: See list NKDA

## DIAGNOSIS: (PLEASE COMPLETE 2<sup>ND</sup> AND 3<sup>RD</sup> DIGITS TO COMPLETE ICD 10 FOR BILLING)

D57.____ - Sickle Cell Disease
____ - Other: _____

## REQUESTED DOCUMENTATION: PREVIOUS ADMINISTRATION: HAS THIS PATIENT TAKEN THIS MEDICATION BEFORE?

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1 Insurance information	IF NO: IF YES:
2 Most recent History & Physical	PLEASE STATE LAST INFUSION DATE:
3 Full medication list	REQUIRED WASHOUT FROM PREVIOUS THERAPY: NEXT INFUSION DATE:
4 Tried and failed therapies	<b>IF ORDER CHANGE:</b>
5	<b>Continue current order until insurance approved</b>
6	

## MEDICATION ORDERS:

NOTE: We may require a detailed Letter of Medical Necessity or clinical supporting documentation (depending on diagnosis), to be able to verify eligibility and payment for this treatment through Medicare and/or other insurance plans.

### DOSE/FREQUENCY:

<input type="checkbox"/>	Induction: Adakveo® 5 mg/kg IV infusion in 100ml NS over 30 minutes at weeks 0, 2, then every 4 weeks
<input type="checkbox"/>	Maintenance: Adakveo® 5mg/kg IV infusion in 100ml NS over 30 minutes every 4 weeks
<input type="checkbox"/>	Other: _____

After administration, flush the line with 25ml 0.9% Sodium Chloride Injection or 5% Dextrose Injection

### SPECIAL/LAB ORDERS:

<input type="checkbox"/>	_____
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Refills x 12 months unless noted otherwise here:

## LINE USE/CARE ORDERS: ADVERSE REACTION & ANAPHYLAXIS ORDERS:

<input checked="" type="checkbox"/> Start PIV/Access CVC <input checked="" type="checkbox"/> Flush device per facility standard flushing procedure <input checked="" type="checkbox"/> Provide nursing care per Palmetto Infusion Nursing Procedures and post procedure observation if indicated	Administer acute infusion and anaphylaxis medications per Palmetto Infusion standing adverse reaction orders, which can be found at our website.
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## PRESCRIBER INFORMATION:

PROVIDER NAME:	PHONE:
ADDRESS:	FAX:
CITY, STATE, ZIP:	NPI:

## PRESCRIBER SIGNATURE: (No stamp signatures) DATE:

_____	_____
Dispense as written/Brand medically necessary	Substitution permitted



## Checklist for referrals to Palmetto Infusion: Fax referral to 1.866.872.8920

- Patient demographics - address, phone number, SS#, etc.**
- Insurance information - copy of the card(s) if possible**
- Plan of Treatment/Orders**
- Most recent physician office notes to include tried and failed therapies - all insurance companies that require a pre-authorization require the note. This includes Medicare/Medicaid HMOs.**
- Any lab results or other diagnostic procedures to support the diagnosis.**

Palmetto Infusion will complete insurance verification and submit all required clinical documentation to the patient's insurance company for eligibility.

Our office will notify you if any further information is required.

We will review financial responsibility with patient and refer them to any available co-pay assistance as required. Palmetto Infusion Call Center 800.809.1265. Thank you for your referral.

[www.palmettoinfusion.com](http://www.palmettoinfusion.com)