VEROS HEALTH
Excellence in Complex Care

crizanlizumab-tmca (ADAKVEO®) Referral Form

Please complete the following and fax with clinical documentation to: 720.279.7461

Referral Process

1. PATIENT INFORMATION (*indicates a required field)	2. PHYSICIAN INFORMATION (*indicates a required field)
Name*: _____	Physician's name*: _____
Address*: _____	License #: _____ NPI #*: _____
City*: _____ State*: _____ Zip*: _____	DEA #: _____ Email*: _____
Home Phone: _____ Mobile Phone*: _____	Address*: _____
Email*: _____ Primary language*: _____	City*: _____ State*: _____ Zip*: _____
DOB*: _____ Social Security #*: _____	Office Contact: _____
Gender*: ☐ M ☐ F Height: _____ Weight*: _____	Phone*: _____ Fax*: _____ Specialty*: _____

Allergies*: _____ NKA*: ☐

Alternate contact name: _____ Alternate contact phone: _____

☐ Yes ☐ No* Consent to leave voice message at the patient and/or alternate contact phone

3. DIAGNOSIS (*indicates a required field) Year of diagnosis: _____

☐ *ICD10 Code: D57. _____ *Description: _____

☐ Other diagnoses: _____

4. INSURANCE INFORMATION

Please submit copies of the front and back of primary and secondary insurance cards with this referral.

5. PRESCRIPTION INFORMATION Anticipated Start Date: _____

Prescription*: crizanlizumab-tmca (ADAKVEO®) 100 mg vial for intravenous use
Prior to administration, dilute doses in 0.9% Sodium Chloride Injection, USP or 5% Dextrose Injection, USP to a total volume of 100 mL for intravenous infusion
Dose: Administer 5 mg/kg by intravenous infusion over a period of 30 minutes at Week 0, Week 2, and every 4 weeks thereafter

Additional orders: _____
Access: ☐ Peripheral Other: _____

FLUSH ORDERS
PIV/midline/PICC: Flush before, after each infusion, and as needed with 3-20 ml NS, followed by Heparin 2-5 ml if indicated
☐ Heparin 10 unit/ml ☐ Heparin 100 unit/ml
Port: Flush before, after each infusion, and as needed with 5-20 ml NS, followed by Heparin 100 unit/ml 5 ml.

ANAPHYLAXIS ORDERS
Adults: For mild reaction-administer diphenhydramine 50mg IVP/PO x 1.
For severe reactions-administer epinephrine 0.3mg SubQ/IM x 1. May repeat x1 if needed. Contact 911 and monitor vital signs.
Pediatrics: *For mild reaction (rash/hives) give diphenhydramine*
Age 12+: 50mg IV/PO x1
For severe reaction (airway closure) administer epinephrine. 0.01mg/kg/dose (max 0.3mg) SubQ/IM x 1.
If needed, repeat a second dose after 5-10 minutes for a maximum of two doses. Contact 911 and monitor vital signs.

☐ Other: _____

6.

PHYSICIAN'S SIGNATURE (required): _____ **Date:** _____

Prescription is valid for one year unless otherwise indicated. The prescriber is to comply with his/her state specific prescription requirements such as e-prescribing, state specific prescription form, fax language, etc. Non-compliance with state specific requirements could result in outreach to the prescriber.