

crizanlizumab-tmca (ADAKVEO[®]) Referral Form

Please complete the following and fax with clinical documentation to: 720.870.2414

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*: _____	City*: _____ State*: _____
Primary language*: _____	Zip*: _____
DOB*: _____ Social Security #*: _____	Office Contact: _____
Gender*: <input type="checkbox"/> M <input type="checkbox"/> F Height: _____ Weight*: _____	Phone*: _____ Fax*: _____
Allergies*: _____ NKA*: <input type="checkbox"/>	Specialty*: _____
Alternate contact name: _____ Alternate contact phone: _____	
<input type="checkbox"/> Yes <input type="checkbox"/> No* Consent to leave voice message at the patient and/or alternate contact phone	
3. DIAGNOSIS (*indicates a required field) Year of diagnosis: _____	
<input type="checkbox"/> *ICD10 Code: D57. _____ *Description: _____	
<input type="checkbox"/> 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 : <input type="checkbox"/> 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	
<input type="checkbox"/> Heparin 10 unit/ml <input type="checkbox"/> 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.	
<input type="checkbox"/> Other: _____	
6.	
PHYSICIAN'S SIGNATURE (required) : _____ Date : _____	