

Enrollee Last Name:

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Enrollee First Name:

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Clinical Criteria – Drug Information

Drug Administration:

Provide the date of drug administration (MM/DD/YYYY):

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Provide the expiration date of the drug if the invoice date is greater than 6 months from the date of drug administration (MM/DD/YYYY):

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Drug Name and Strength:

ADAKVEO 100 MG/10 ML VIAL

Directions: _____

Quantity: _____

New Treatment: Yes No

If **No**, date therapy initiated: _____

Clinical Criteria – Diagnosis

1. Sickle Cell Disease

2. Is the patient 16 years of age or older? Yes No

Attestation

I attest that this is medically necessary for this patient and that all of the information on this form is accurate to the best of my knowledge. I attest that documentation of the above diagnosis and medical necessity is available for review if requested by the New York State Medicaid Program.

Prescriber Signature (Required)

Date (MM/DD/YYYY)