

**Clinical Criteria Worksheet:
ADAKVEO® (crizanlizumab-tmca)**

Claim Submission

- Claim processing may be delayed if the information submitted in this worksheet is illegible.
- If the worksheet is left blank or information is missing the claim will be rejected for not enough documentation and reimbursement will be delayed.
- A claim should not be submitted until the drug has been administered to the patient.
- The manufacturer invoice showing the acquisition cost of the drug administered, including all discounts, rebates, and incentives must be submitted with the claim. The invoice must be dated within 6 months prior to the date of service and/or should include the expiration date of the drug, or it will be rejected for not enough documentation.

Enrollee Information

Enrollee Last Name:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Enrollee First Name:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Date of Birth (MM/DD/YYYY):

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Enrollee Medicaid ID (2 letters, 5 numbers, 1 letter):

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Address:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

City, Town or Post Office:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

State:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

ZIP Code:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Prescriber Information

Prescriber Last Name:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Prescriber First Name:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

National Provider Identifier (NPI) Number:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Preferred Contact (Telephone Number)

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Enrollee Last Name:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Enrollee First Name:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Clinical Criteria – Drug Information

Drug Administration:

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

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

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):

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

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)