Beacon Infusion
Healthcare Services

Headquarters Location:
1075 Stephenson Ave, Suite D-2, Oceanport, NJ 07757
Telephone: (833) 223-2266 Fax: (732) 329-2322

ADAKVEO MEDICATION ORDER

Patient's Name (Last, First, Middle) _____ **DOB:** _____
Pt must be age 16+

■ Diagnosis
Select the most specific code. If there is a blank, the code must be completed.

- ☐ D57.03 Hb-SS with cerebral vascular involvement
- ☐ D57.09 Hb-SS with crisis other specified complication
- ☐ D57.213 Sickle-cell/Hb-C with cerebro-vasc involv
- ☐ D57.218 Sickle-cell/Hb-C w/crisis w/other spec compl
- ☐ D57.41__ Sickle-cell thalassemia unspec w/_____
- ☐ D57.42 Sickle-cell thalassemia beta zero w/o crisis
- ☐ D57.43__ Sickle-cell thalassemia beta zero w/_____
- ☐ D57.44 Sickle-cell thalassemia beta+ w/o crisis
- ☐ D57.45__ Sickle-cell thalassemia beta+ w/_____
- ☐ D57.813 Other sickle-cell with CV involv
- ☐ D57.818 Other sickle-cell w/crisis w/other spec compl

■ Details Needed for Authorization
Please answer all questions, and provide supporting documentation.

- Does the patient have significant qty of HbS w/ or w/o add'l abnormal β-globin chain variant by hemoglobin assay? _____
- Does the patient have biallelic HBB pathogenic variants where at least 1 allele is the p.Glu6Val pathogenic variant on molecular genetic testing? _____
- Has the patient had at least 1 sickle cell crisis within the preceding 12 months which includes receipt of pain medication? _____
- Has the patient tried and failed on generic hydroxyurea? _____
- If the patient is on concomitant hydroxyurea, was it started at least 6 months ago, and stable for at least 3 months? _____
- If the patient is on concomitant erythropoetin, was it started at least 6 months ago, and stable for at least 3 months? _____
- Is the patient on concomitant Oxbryta (voxelotor) tablets? _____
- Is the patient on concomitant Endari (L-glutamine oral powder)? _____

■ Adakveo (crizanlizumab-tmca) Medication Order
Patient's height in ft/in: _____ Patient's weight in lbs: _____

Select all doses required.

☐ Initial dose: 5 mg/kg by IV over a period of 30 minutes at weeks 0 and 2

☐ Maintenance dose: 5 mg/kg by IV over a period of 30 minutes every 4 weeks for _____ months.

Medication shall be brought to room temperature over 4 hours. Do not shake the vials. Inject the appropriate dose to a 100ml 0.9% NaCl infusion bag. Gently invert the bag to mix, do not shake. The IV line shall have a 0.2 or 0.22 micron in-line filter attached. Post infusion flush with normal saline. Check vitals and monitor for signs and symptoms at start, throughout infusion, and after completion.

■ Rescue Management in case of Infusion Therapy Reaction
These include fever, chills, rigors, headache, rash, itching, swelling, edema, nausea, vomiting, abdominal pain, hypotension, and respiratory distress.

- Stop medication infusion and start normal saline infusion at 50 ml/hr. Call ordering provider to report reaction.
- Follow standing reaction orders, including diphenhydramine, methylprednisolone, albuterol and oxygen as needed. Exercise caution with corticosteroids in patients with sickle cell disease unless clinically indicated.
- For severe reactions, administer Epi-pen or equivalent and call 911. Repeat if severe symptoms persist.

■ Ordering Provider Authorization

Provider's Signature: _____ Name: _____ Date: _____

Address: _____

Phone: _____ Fax: _____ NPI #: _____ License: _____

STANDARD DOCUMENTATION TO INCLUDE:

- Patient demographics and insurance, including card scans (both medical and pharmacy benefit cards, both sides).
- Most recent chart notes and, if available, last history and physical. All relevant scans, tests and laboratory results.
- If new medication for patient, chart notes which include decision to begin treatment. If not, provide last treatment date.

Fax this order and supporting documentation to (732) 329-2322.