Clinical Criteria Worksheet: ADAKVEO® (crizanlizumab-tmca)

Claim Submission

Enrollee Information

- 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.

Enro	Enrollee Last Name:													Enrollee First Name:											
Date of Birth (MM/DD/YYYY):													Enrollee Medicaid ID (2 letters, 5 numbers, 1 letter):												
	/ / / /																								
Add	ress	:			_					_												_			
City	City, Town or Post Office:																	State:			ZIP Code:				
Pre	escr	ibe	r In	for	ma	tior	1																		
Pres	scrib	er La	ast N	lame	:								Prescriber First Name:												
Nati	iona	l Pro	vide	r Ide	entifi	er(I	NPI)	Nun	nber	:															
Pref	erre	d Co	ntac	t (Te	elepl	none	Nur	nbe	r)																
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Enrollee Last Name:								_	Enro	llee	First	Nan	ne:											
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Cli	Clinical Criteria – Drug Information																							
Dru	ıg Ad	mini	stra	tion:																				
Pro	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										
Dru	ıg Na	me a	and S	Strer	ngth:																			
Drug Name and Strength: ADAKVEO 100 MG/10 ML VIAL																								
Dir	Directions:																							
Qu	Quantity:																							
New Treatment:																								
Clinical Criteria – Diagnosis																								
1.	S	ickle	Cell	Dise	ease																			
2.	Is the	e pai	tient	:16 y	ears/	of ag	ge o	r old	er?		ſ		Yes			No								
At	test	atio	on																					
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.																								
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