aleracare
advanced infusion centers™

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Adakveo (crizanlizumab-tmca)

Provider Order Form rev. 8/16/2024

Patient Information

Patient Name: DOB:

Patient Home Phone: Patient Cell Phone: Patient Email:

Emergency/Alternate Contact Name: Emergency/Alternate Contact Phone:

NKDA Allergies: Weight lbs/kg: Height:

Patient Status: New to Therapy Continuing Therapy Therapy Change Last infusion date (if applicable): ____________________

Is the patient pregnant, planning a pregnancy or nursing: Yes No Does the patient need interpreter services: Yes No

Provider Information

Referral Coordinator Name: Referral Coordinator Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip:

ICD-10 CODE

D57.00 Sickle cell anemia with crisis unspecified D57.3 Sickle-cell trait D57.419 Sickle-cell thalassemia with crisis unspecified

D57.814 Other sickle-cell disorders with crisis with other specified complication Other: ____

Medication Order

Adakveo (crizanlizumab-tmca)

Dose and frequency: 5 mg/kg IV week 0, week 2, and then every 4 weeks 5 mg/kg IV every 4 weeks

Documentation Required (Note: Send all labs, must include specific labs listed here)

Labs Insurance Card (front and back) Current Medications History/Progress Notes

Pre-Medication Order

acetaminophen (Tylenol) 500mg 650mg 1000mg PO **diphenhydramine** (Benadryl) 25mg 50mg / PO IV

cetirizine (Zyrtec) 10mg PO **methylprednisolone** (Solu-Medrol) 40mg IV 125mg IV

loratadine (Claritin) 10mg PO **hydrocortisone** (Solu-Cortef) 100mg IV

Other: ____

Dose:__________________ Route:__________________ Frequency: __________________

Special Instructions (Prior therapy, treatment dates, and reasons for d/c)

Provider Name

Provider Signature

Date

Check here if this is a stat order

Order is valid for 1 year from date of signature and refills will be provided to cover the duration of treatment unless otherwise indicated.