immersiv HEALTH

# ADAKVEO® ORDER FORM

**FAX TO: 855.694.4656**

## PATIENT INFORMATION

**PATIENT NAME:** _____ **PHONE:** _____

**DATE OF BIRTH:** _____ **SEX:** ☐ M ☐ F **HEIGHT:** _____ **WEIGHT:** _____ ☐ LBS ☐ KG

**ALLERGIES:** _____ **PREFERRED CLINIC:** _____

**REFERRAL STATUS:** ☐ NEW REFERRAL ☐ ORDER CHANGE ☐ ORDER RENEWAL

## DIAGNOSIS & CLINICAL DOCUMENTATION

***PLEASE COMPLETE ICD-10 FOR SPECIFIC DIAGNOSIS**

☐ D57. ___ Sickle Cell Disease

☐ ICD-10 CODE: _____ DESCRIPTION: _____

## REQUIRED DOCUMENTATION

☐ Insurance Information

☐ List of Medications

☐ Tried & Failed Therapies

☐ Most Recent History & Physical

## MEDICATION ORDER

☐ **LOADING:** Adakveo® (crizanlizumab) 5mg/kg IV in 100ml NS over 30 minutes at week 0 and week 2

☐ **MAINTENANCE:** Adakveo® (crizanlizumab) 5mg/kg IV in 100ml NS over 30 minutes every 4 weeks

*Maintenance dosing scheduled 4 weeks from last loading dose (week 2 dose)

*Flush with 30ml NS after each infusion

☑ REFILL X 12 MONTHS UNLESS OTHERWISE NOTED HERE: _____

### PRE-MEDICATIONS

**PO**

☐ Acetaminophen: 650 mg

☐ Cetirizine: 10 mg

☐ Diphenhydramine: 25 mg

**IV**

☐ Methylprednisolone: 125 mg

☐ Diphenhydramine: 25 mg

☐ **OTHER:** _____ ☐ PO ☐ IV

Patient to be observed for 30 minutes following the first administration.
In the event of an adverse reaction occurring in the infusion clinic, utilize the Immersiv Health adverse reaction protocol.

## PRESCRIBER INFORMATION

**PROVIDER NAME:** _____ **NPI #:** _____

**EMAIL:** _____ **PHONE:** _____ **FAX:** _____

**ADDRESS (INCLUDE CITY, STATE, ZIP):** _____

**SUPERVISING PHYSICIAN:** _____ **CONTACT NAME:** _____
(IF APPLICABLE)

**SIGNATURE:** _____ _____ **DATE:** _____
(NO STAMPS)

SUBSTITUTION PERMITTED | DISPENSE AS WRITTEN