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. Administer per protocol.
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