**Louisiana Medicaid**
**Crizanlizumab-tmca (Adakveo®)**

The *Louisiana Uniform Prescription Drug Prior Authorization Form* should be utilized to request clinical authorization for crizanlizumab-tmca (Adakveo®).

Additional Point-of-Sale edits may apply.

## Approval Criteria

- The recipient is 16 years of age or older on the date of the request; **AND**
- The recipient has a diagnosis of sickle cell disease; **AND**
- If possible, crizanlizumab-tmca (Adakveo®) is prescribed by, or the request states that this medication is being prescribed in consultation with, a hematologist or oncologist; **AND**
- The request lists dates of **TWO** or more sickle cell-related pain crises within the previous 12 months, where painful crisis is defined by **EITHER**:
    - a visit to an emergency room/medical facility for sickle cell disease-related pain which was treated with a parenterally administered narcotic or parenterally administered ketorolac; **OR**
    - the occurrence of chest syndrome, priapism, or splenic sequestration; **AND**
- **ONE** of the following is **stated on the request**:
    - The recipient is currently receiving hydroxyurea therapy; **OR**
    - The recipient has a history of treatment failure, intolerance, or contraindication to hydroxyurea therapy; **AND**
- By submitting the authorization request, the prescriber attests to the following:
    - The prescribing information for the requested medication has been thoroughly reviewed, including any Black Box Warning, Risk Evaluation and Mitigation Strategy (REMS), contraindications, minimum age requirements, recommended dosing, and prior treatment requirements; **AND**
    - All laboratory testing and clinical monitoring recommended in the prescribing information have been completed as of the date of the request and will be repeated as recommended; **AND**
    - The recipient has no concomitant drug therapies or disease states that limit the use of the requested medication and will not be receiving the requested medication in combination with any other medication that is contraindicated or not recommended per FDA labeling.

**Duration of initial approval: 6 months**

## Reauthorization Criteria

- The recipient continues to meet initial approval criteria; **AND**
- The prescriber **states on the request** that the recipient is established on the medication with evidence of a positive response to therapy.

**Duration of reauthorization approval: 12 months**

## References

Adakveo (crizanlizumab-tmca) [package insert]. East Hanover, NJ: Novartis Pharmaceuticals Corporation; November 2019. https://www.novartis.us/sites/www.novartis.us/files/adakveo.pdf

U.S. Department of Health and Human Services, National Institutes of Health, National Heart, Lung, and Blood Institute. (2014). *Evidence-Based Management of Sickle Cell Disease: Expert Panel Report, 2014*. Retrieved from http://www.nhlbi.nih.gov/guidelines

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