ADAKVEO
(crizanlizumab)

FLOURISH™ HEALTH GROUP

PATIENT DEMOGRAPHICS

Patient Name:	Patient's Phone Number:
Date of Birth:	Address:
Allergies: See List ☐ NKDA ☐	City, State, Zip:
Weight:_____lbs or _____kg	Patient's Email:

REQUIRED DOCUMENTATION

• Insurance Card • History & Physical • Patient Demographics • Most Recent Labs • Medication List

• Tried/Failed Hydroxyurea ☐ Y ☐ N • # of VOC's in previous 12 months: _____

PRIMARY DIAGNOSIS

☐ D57.1 Sickle cell disease without crisis
☐ D57.3 Sickle cell trait
☐ D57.40 Sickle cell thalassemia with crisis
☐ D57.80 Other sickle cell disorders without crisis
☐ D57.81 Other sickle cell disorders with crisis
☐ Other: _____

LAB ORDERS: PLEASE INCLUDE FREQUENCY

Please list any labs to be drawn by the infusion clinic: _____

PRE-MEDICATIONS

*Per infusion clinic protocol, there are no recommended standard pre-meds for Adakveo
☐ Provider Prescribed: _____

PRIMARY MEDICATION ORDER

☐ Adakveo 5 mg/kg IV at weeks 0, 2, and every 4 weeks thereafter
☐ Adakveo 5 mg/kg IV every 4 weeks
☐ Other: _____

First Dose: ☐ Y ☐ N ☑ Refill x12 months unless otherwise noted: _____

LINE USE/CARE ORDERS

☑ Start PIV/ACCESS CVC ☑ Flush device per Flourish Health Group's protocol (See flourishhealth.com for detailed policy)
☐ Other Flush Orders: Please fax other line care orders if checking this box

ADVERSE REACTION & ANAPHYLAXIS ORDERS

☑ Administer acute infusion reaction and anaphylaxis medications per Flourish Health Group's protocol (See flourishhealth.com for detailed policy)
☐ Other: Please fax other reaction orders if checking this box

PROVIDER INFORMATION: PLEASE CHECK PREFERRED FORM OF COMMUNICATION

Provider Name:	Office Contact:
Address:	Phone:
City, State, Zip:	☐ Fax:
NPI **AND** License:	☐ Email:

_____ _____
Provider Signature Date