**Adakveo (crizanlizumab-tcma)**

**Effective 06/01/20**

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<td>☒ Prior Authorization</td>
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**Specialty Limitations**

N/A

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**Specialty Medications**

All Plans

Phone: 866-814-5506  
Fax: 866-249-6155

**Non-Specialty Medications**

<table>
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<tr>
<th>MassHealth</th>
<th>Phone: 877-433-7643</th>
<th>Fax: 866-255-7569</th>
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<tr>
<td>Commercial</td>
<td>Phone: 800-294-5979</td>
<td>Fax: 888-836-0730</td>
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<td>Exchange</td>
<td>Phone: 855-582-2022</td>
<td>Fax: 855-245-2134</td>
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**Medical Specialty Medications (NLX)**

All Plans

Phone: 844-345-2803  
Fax: 844-851-0882

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**Contact Information**

**Overview**

Crizanlizumab is a humanized IgG₂ kappa monoclonal antibody which binds to P-selectin and blocks interaction with ligands, including P-selectin glycoprotein ligand 1. Translocation of P-selectin to the activated endothelial cell surface results in adhesion of sickle erythrocytes to vessels and the development of vascular occlusion. By binding to P-selectin, crizanlizumab inhibits interactions between endothelial cells, platelets, red blood cells, and leukocytes, which may result in decreased platelet aggregation, maintenance of blood flow, and minimized sickle cell-related pain crises.

**Coverage Guidelines**

Authorization may be granted for members who are currently receiving treatment with Adakveo, excluding when the product is obtained as samples or via manufacturer’s patient assistance programs  
**OR**

Authorization may be granted if the member meets all following criteria and documentation has been submitted:

1. The member is using Adakveo to reduce the frequency of vaso-occlusive crises (VOC) with sickle cell disease
2. The member age is ≥ 16 years
3. The prescriber specialty is a hematologist or medication is being used in consultation with a hematologist.
4. The member has experienced two or more sickle cell crises in the previous 12 months
5. The member has had inadequate response to hydroxyurea at maximally tolerated dose for at least 3 months **OR** had an adverse reaction or contraindication to hydroxyurea
**Continuation of Therapy**
Reauthorization may be granted for members who have met the initial criteria and the physician has submitted clinical documentation of clinical response as evidenced (e.g., decrease in VOCs, reduction in need for pain management, decrease in hospitalizations).

**Limitations**
1. Initial approvals will be granted for 6 months
2. Reauthorization may be granted for 12 months

**References**
2. Hydrea (hydroxyurea) [prescribing information]. Princeton, NJ: Bristol-Myers Squibb Company; December 2019

**Review History**
03/18/2020 – Created and Reviewed P&T Mtg (effective 6/1/20)

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