

Adakveo (crizanlizumab-tcma)
Effective 06/01/20

Plan	<input checked="" type="checkbox"/> MassHealth <input checked="" type="checkbox"/> Commercial/Exchange	Program Type	<input checked="" type="checkbox"/> Prior Authorization <input type="checkbox"/> Quantity Limit <input type="checkbox"/> Step Therapy
Benefit	<input type="checkbox"/> Pharmacy Benefit <input checked="" type="checkbox"/> Medical Benefit (NLX)		
Specialty Limitations	N/A		
Contact Information	Specialty Medications		
	All Plans	Phone: 866-814-5506	Fax: 866-249-6155
	Non-Specialty Medications		
	MassHealth	Phone: 877-433-7643	Fax: 866-255-7569
	Commercial	Phone: 800-294-5979	Fax: 888-836-0730
	Exchange	Phone: 855-582-2022	Fax: 855-245-2134
	Medical Specialty Medications (NLX)		
	All Plans	Phone: 844-345-2803	Fax: 844-851-0882
Exceptions			

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

1. Adakveo (crizanlizumab) [prescribing information]. East Hanover, NJ: Novartis Pharmaceuticals Corporation; November 2019.
2. Hydrea (hydroxyurea) [prescribing information]. Princeton, NJ: Bristol-Myers Squibb Company; December 2019

Review History

03/18/2020 – Created and Reviewed P&T Mtg

05/20/2020 – reviewed May P&T Mtg; no clinical updates

Disclaimer

AllWays Health Partners complies with applicable federal civil rights laws and does not discriminate or exclude people on the basis of race, color, national origin, age, disability, or sex.