Berinert, Cinryze

Prior Authorization Request

Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-855-330-1720

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-855-330-1720**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-866-814-5506.** For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

The recipient of this fax may make a request to opt-out of receiving telemarketing fax transmissions from CVS Caremark. There are numerous ways you may opt-out: The recipient may call the toll-free number at 877-265-2711, at any time, 24 hours a day/7 days a week. The recipient may also send an opt-out request via email to do_not_call@cvscaremark.com. An opt out request is only valid if it (1) identifies the number to which the request relates, and (2) if the person/entity making the request does not, subsequent to the request, provide express invitation or permission to CVS Caremark to send facsimile advertisements to such person/entity at that particular number. CVS Caremark is required by law to honor an opt-out request within thirty days of receipt.

Patient's Name: _____ **Date**: _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____

Referring Provider Info: ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Rendering Provider Info: ❑ **Same as Referring Provider** ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Required Demographic Information:

Patient Weight: _____*kg*

*Patient Height:*_____*cm*

Please indicate the place of service for the requested drug:
❑ *Ambulatory Surgical* ❑ *Home* ❑ *Inpatient Hospital* ❑ *Off Campus Outpatient Hospital*
❑ *On Campus Outpatient Hospital* ❑ *Office* ❑ *Pharmacy*

Exception Criteria Questions:

A. What is the prescribed drug? ❑ Cinryze, *skip to Clinical Criteria Questions* ❑ Berinert

B. The preferred product for your patient's health plan is Ruconest. Can the patient's treatment be switched to Ruconest? ❑ Yes *If Yes, Please obtain Ruconest PA Form* ❑ No

C. Is this request for continuation of therapy with the requested product? ❑ Yes ❑ No, *skip to Question E*

D. Is the patient currently receiving the requested product through samples or a manufacturer's patient assistance program? If unknown, answer 'Yes' ❑ Yes ❑ No, *skip to Clinical Criteria Questions*

E. Has the patient had a documented inadequate response to treatment with Ruconest? **Action Required:** ***If 'Yes', attach supporting chart note(s).*** ❑ Yes, *skip to Clinical Criteria Questions* ❑ No

F. Has the patient experienced a documented intolerable adverse event to Ruconest? **Action Required:** ***If 'Yes', attach supporting chart note(s).*** ❑ Yes, *skip to Clinical Criteria Questions* ❑ No

G. Does the patient have a documented contraindication to Ruconest (i.e., a known or suspected allergy to rabbits or rabbit-derived products)? **Action Required:** ***If 'Yes', attach supporting chart note(s).***
❑ Yes, *skip to Clinical Criteria Questions* ❑ No

H. Is Berinert being requested for the treatment of laryngeal attacks? ❑ Yes ❑ No

Clinical Criteria Questions:

1. What is the patient's diagnosis? ***ACTION REQUIRED: Attach documentation of C4 levels and C1 inhibitor functional and antigenic protein levels.***
   ❑ Hereditary angioedema (HAE) with C1 inhibitor deficiency confirmed by laboratory testing, *skip to #3*
   ❑ HAE with normal C1 inhibitor confirmed by laboratory testing
   ❑ Other _____
2. Which of the following conditions does the patient have?
   ❒ F12, angiopoietin-1, or plasminogen gene mutation as confirmed by genetic testing
   ❒ Family history of angioedema AND angioedema refractory to trial of high-dose antihistamine (eg, cetirizine) for greater than or equal to 1 month
   ❒ Other _____
3. What is the requested ICD-10: _____
4. Is the requested drug being used for the treatment of acute HAE attacks? ❑ Yes ❑ No
5. Is requested drug being used for the prevention of future HAE attacks? ❑ Yes ❑ No
6. Has the patient recieved treatment with the requested product? ❑ Yes ❑ No *If No, no further questions.*
7. Has the patient experienced reduction in frequency, severity, and duration of attacks since starting treatment? ❑ Yes ❑ No

Step Therapy Override: Complete if Applicable.	Please Circle	
Is the requested drug being used to treat stage four advanced metastatic cancer?	Yes	No
Is the requested drug's use consistent with the FDA-approved indication or the National Comprehensive Cancer Network Drugs & Biologics Compendium indication for the treatment of stage four advanced metastatic cancer and is supported by peer-reviewed medical literature?	Yes	No
Is the requested drug being used for an FDA-approved indication OR an indication supported in the compendia of current literature (examples: AHFS, Lexicomp, Clinical Pharmacology, Micromedex, current accepted guidelines)?	Yes	No
Does the prescribed quantity fall within the manufacturer's published dosing guidelines or within dosing guidelines found in the compendia of current literature (examples: package insert, AHFS, Lexicomp, Clinical Pharmacology, Micromedex, current accepted guidelines)?	Yes	No
Do patient chart notes document the requested drug was ordered with a paid claim at the pharmacy, the pharmacy filled the prescription and delivered to the patient or other documentation that the requested drug was prescribed for the patient in the last 180 days?	Yes	No
Has the prescriber provided proof documented in the patient chart notes that in their opinion the requested drug is effective for the patient's condition?	Yes	No

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X_____

Prescriber or Authorized Signature **Date (mm/dd/yy)**