Berinert

Prior Authorization Request

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 1-866-249-6155**. 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: _____
Request Initiated For: _____

1. What is the diagnosis?
   ❑ Hereditary angioedema (HAE) with C1 inhibitor deficiency or dysfunction confirmed by laboratory testing
   ❑ Hereditary angioedema (HAE) with normal C1 inhibitor confirmed by laboratory testing
   ❑ Other _____
2. What is the ICD-10 code? _____
3. What is the patient's body weight? _____ kg or lbs ***(circle one)***
4. The preferred products for your patient's health plan are generic icatibant and Ruconest. Can the patient's treatment be switched to generic icatibant or Ruconest?
   ❑ Yes - Please specify: _____
   If Yes, please call 1-866-814-5506 to have the updated form faxed to your office OR you may complete the PA electronically (ePA). You may sign up online via CoverMyMeds at: www.covermymeds.com/epa/caremark/ or call 1-866-452-5017.
   ❑ No - Continue request for Berinert
5. Is the product being requested for short-term preprocedural prophylaxis (i.e., prior to surgical or major dental procedures)? *If Yes, skip to #9* ❑ Yes ❑ No
6. *If the patient is 13 years of age or older*, is the product being requested for the treatment of laryngeal attacks?
   ❑ Yes ❑ No ❑ Not applicable - patient is less than 13 years of age, *skip to #9*
7. Does the patient have a documented inadequate response and/or intolerable adverse event to treatment with the preferred product? ***ACTION REQUIRED: If Yes, attach supporting chart note(s).***
   Indicate ALL that apply.
   ❑ Ruconest ❑ Inadequate response ❑ Intolerable adverse event
   ❑ No - none of the above
8. 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 ❑ No

Send completed form to: Case Review Unit, CVS Caremark Prior Authorization Fax: 1-866-249-6155

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9. Will the requested drug be prescribed by or in consultation with a prescriber who specializes in the management of hereditary angioedema (HAE)? ❑ Yes ❑ No

10. What is the clinical setting in which the requested medication will be used?
❑ Short-term preprocedural prophylaxis (i.e., prior to surgical or major dental procedures), *skip to diagnosis section*
❑ Acute hereditary angioedema (HAE) attacks
❑ Other _____

11. Will the requested drug be used in combination with any other medication used for treatment of acute hereditary angioedema (HAE) attacks (e.g., Ruconest, Firazyr, Kalbitor)? ❑ Yes ❑ No

12. Has the patient previously received treatment with the requested medication?
❑ Yes ❑ No *If No, skip to diagnosis section.*

13. Has the patient experienced a reduction in severity and/or duration of acute attacks? ***ACTION REQUIRED: If Yes, attach supporting chart note(s) demonstrating a reduction in severity and/or duration of acute attacks.***
❑ Yes ❑ No

14. Does the patient's attack frequency, attack severity, comorbid conditions and patient's quality of life warrant prophylactic therapy? ❑ Yes ❑ No *If No, skip to diagnosis section.*

15. Has prophylactic treatment been considered? ❑ Yes ❑ No
*If No, please provide a brief rationale as to why prophylactic treatment has not been considered:*_____
_____

Complete the following section based on the patient's diagnosis, if applicable.

Section A: Hereditary Angioedema (HAE) with C1 Inhibitor Deficiency or Dysfunction Confirmed by Laboratory Testing

16. Which of the following conditions does the patient have at the time of diagnosis? ***ACTION REQUIRED: For any answer, attach laboratory test or medical record documentation confirming C1 inhibitor functional and antigenic protein levels.***
❑ A C1 inhibitor (C1-INH) antigenic level below the lower limit of normal as defined by the laboratory performing the test
❑ A normal C1-INH antigenic level and a low C1-INH functional level (functional C1-INH less than 50% or C1-INH functional level below the lower limit of normal as defined by the laboratory performing the test)
❑ Other _____

Section B: Hereditary Angioedema (HAE) with Normal C1 Inhibitor Confirmed by Laboratory Testing

17. Which of the following conditions does the patient have at the time of diagnosis? ***ACTION REQUIRED: For any answer, attach laboratory test or medical record documentation confirming normal C1 inhibitor. Based on the answer provided, attach genetic test or medical record documentation confirming F12, angiopoietin-1, plasminogen, kininogen-1 (KNG1), heparan sulfate-glucosamine 3-O-sulfotransferase 6 (HS3ST6), or myoferlin (MYOF) gene mutation testing or chart notes confirming family history of angioedema and the angioedema was refractory to a trial of high-dose antihistamine therapy.***
❑ F12, angiopoietin-1, plasminogen, kininogen-1 (KNG1), heparan sulfate-glucosamine 3-O-sulfotransferase 6 (HS3ST6), or myoferlin (MYOF) gene mutation as confirmed by genetic testing
❑ BOTH of the following: 1) Angioedema refractory to a trial of high-dose antihistamine therapy (i.e., cetirizine at 40 mg per day or the equivalent) for at least one month AND 2) Family history of angioedema
❑ Other _____

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)**

Send completed form to: Case Review Unit, CVS Caremark Prior Authorization Fax: 1-866-249-6155