Cinryze

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 1-855-330-1720**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-888-877-0518.** 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.

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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*

Site of Service Questions (SOS):

A. Indicate the site of service requested:
- ❑ On Campus Outpatient Hospital
- ❑ Off Campus Outpatient Hospital
- ❑ Home infusion, *skip to Criteria Questions*
- ❑ Physician office, *skip to Criteria Questions*
- ❑ Ambulatory surgical, *skip to Criteria Questions*
- ❑ Pharmacy, *skip to Criteria Questions*

B. Is this request to continue previously established treatment with the requested medication?
❑ Yes – This is a continuation of an existing treatment
❑ No – This is a new therapy request (patient has not received requested medication in the last 6 months). *Skip to Clinical Criteria Questions*

C. Has the patient experienced an adverse event with the requested product that has not responded to conventional interventions (eg acetaminophen, steroids, diphenhydramine, fluids, other pre-medications) or a severe adverse event (anaphylaxis, anaphylactoid reactions, myocardial infarction, thromboembolism, or seizures) during or immediately after an infusion? ***ACTION REQUIRED: If Yes, please attach supporting clinical documentation.***
❑ Yes, *skip to Clinical Criteria Questions* ❑ No

D. Is the patient medically unstable which may include respiratory, cardiovascular, or renal conditions that may limit the member's ability to tolerate a large volume or load or predispose the member to a severe adverse event that cannot be managed in an alternate setting without appropriate medical personnel and equipment?
ACTION REQUIRED: If Yes, please attach supporting clinical documentation.
❑ Yes, *skip to Clinical Criteria Questions* ❑ No

E. Does the patient have severe venous access issues that require the use of a special interventions only available in the outpatient hospital setting? ***ACTION REQUIRED: If Yes, please attach supporting clinical documentation.***
❑ Yes, *skip to Clinical Criteria Questions* ❑ No

F. Does the patient have significant behavioral issues and/or physical or cognitive impairment that would impact the safety of the infusion therapy AND the patient does not have access to a caregiver?
ACTION REQUIRED: If Yes, please attach supporting clinical documentation. ❑ Yes ❑ No

Clinical Criteria Questions:

1. What is the diagnosis?
   ❑ Hereditary angioedema (HAE) with C1 inhibitor deficiency or dysfunction confirmed by laboratory testing
   ❑ HAE with normal C1 inhibitor confirmed by laboratory testing
   ❑ Other ____

2. What is the ICD-10 code? ____________

3. Is Cinryze being used for the prevention of HAE attacks? ❑ Yes ❑ No

4. How many HAE attacks does the patient have per month? ________ attacks

5. Will Cinryze be used in combination with any other medication used for the prophylaxis of HAE attacks?
   ❑ Yes ❑ No

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

7. Has the patient experienced a significant reduction in frequency of attacks (e.g. >= 50%) since starting treatment?
   ACTION REQUIRED: If "Yes", attach chart notes demonstrating a reduction in the frequency of attacks
   ❑ Yes ❑ No

8. Has the patient reduced the use of medications to treat acute attacks since starting treatment with the requested medication? ❑ Yes ❑ No

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

Section A: HAE with C1 Inhibitor Deficiency or Dysfunction Confirmed by Laboratory Testing

9. Does the patient have a C4 level below the lower limit of normal as defined by the laboratory performing the test?
   ACTION REQUIRED: If 'Yes', attach laboratory test or medical record documentation confirming low C4 level.
   ❑ Yes ❑ No

10. Which of the following conditions does the patient have? ***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: HAE with Normal C1 Inhibitor Confirmed by Laboratory Testing

11. Which of the following conditions does the patient have? ***ACTION REQUIRED For any answer, attach laboratory test or medical record documentation confirming C4 levels and normal C1 inhibitor. Based on the answer provided, attach genetic test or medical record documentation confirming F12, angiopoietin-1, plasminogen, or kininogen-1 (KNG1) gene mutation testing or chart notes confirming family history of angioedema.***
    ❑ F12, angiopoietin-1, plasminogen, or kininogen-1 (KNG1) gene mutation as confirmed by genetic testing
    ❑ Family history of angioedema and angioedema refractory to a trial of high-dose antihistamine (e.g. cetirizine) for at least one month
    ❑ 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 Specialty Programs Fax: 1-855-330-1720

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