CareFirst Family of health care plans

CVS caremark™

# Firazyr

## Prior Authorization Request

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

CVS Caremark administers the prescription benefit plan for the member 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.

**PATIENT INFORMATION**

**Date:** _____
**Name:** _____
**ID:** _____
**Date of Birth:** _____
**Request Initiated For:** _____

**PRESCRIBER INFORMATION**

**Name:** _____
**Office Telephone:** _____
**Office Fax:** _____
**Specialty:** _____
**NPI#:** _____

**PATIENT DIAGNOSIS & ICD-10 CODE**

***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
❑ HAE with normal C1 inhibitor confirmed by laboratory testing
❑ Other _____

ICD-10: _____

**DIAGNOSIS SPECIFIC QUESTIONS**

**All Diagnoses**

1. Is Firazyr being used for the treatment of acute HAE attacks? ❑ Yes ❑ No
2. Has the patient received treatment with Firazyr? ❑ Yes ❑ No *If Yes, no further questions*
3. Has the patient experienced reduction in severity and duration of attacks since starting treatment? ❑ Yes ❑ No

**HAE with Normal C1 Inhibitor Confirmed by Laboratory Testing**

1. Which of the following conditions does the patient have?
   ❒ F12 gene mutation as confirmed by genetic testing
   ❒ Family history of angioedema AND angioedema refractory to trial of antihistamine (eg, cetirizine) for greater than or equal to 1 month
   ❒ Other _____

**AUTHORIZATION**

***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)**