Ruconest (for Maryland only)
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 INFORMATION
Date: _____
Name: _____
ID: _____
Date of Birth: _____
Request Initiated For: _____

PRESCRIBER INFORMATION
Name: _____
Office Telephone: _____
Office Fax: _____
Specialty: _____
NPI#: _____

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

Additional Demographic Information:

Patient Weight: _____*kg*

*Patient Height:*_____*ft* _____*inches*

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. Would the prescriber like to request an override of the step therapy requirement? ❑ Yes ❑ No *If No, skip to #4*

2. Has the member received the medication through a pharmacy or medical benefit within the past 180 days? ❑ Yes ❑ No ***Action Required: If Yes, please provide documentation to substantiate the member had a prescription paid for within the past 180 days (i.e. PBM medication history, pharmacy receipt, EOB etc.)***

3. Is the medication effective in treating the member's condition? ❑ Yes ❑ No *Continue to #4 and complete this form in its entirety.*

4. Is Ruconest being used for the treatment of acute HAE attacks? ❑ Yes ❑ No

5. Has the patient received treatment with Ruconest? ❑ Yes ❑ No *If No, no further questions*

6. 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 _____

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)**