

**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.

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**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*

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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)