Ruconest

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#: _____

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*

Please indicate the place of service for the requested drug:
❑ *Ambulatory Surgical* ❑ *Home* ❑ *Inpatient Hospital* ❑ *Off Campus Outpatient Hospital*
❑ *On Campus Outpatient Hospital* ❑ *Office* ❑ *Pharmacy*

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. *If patient's diagnosis is HAE with normal C1 inhibitor confirmed by laboratory testing,* which of the following conditions does the patient have?
   - ❑ F12, angiopoietin- 1, or plasminogen gene mutation as confirmed by genetic testing
   - ❑ Family history of angioedema AND angioedema refractory to a trial of high-dose antihistamine (e.g. cetirizine) ≥ one month
   - ❑ Other _____
4. Is Ruconest being used for the treatment of acute HAE attacks? ❑ Yes ❑ No
5. Has the patient received treatment with Ruconest? ***ACTION REQUIRED: Attach documentation of C4 levels and C1 inhibitor functional and antigenic protein levels.*** ❑ Yes ❑ No *If No, no further questions*
6. Has the patient experienced reduction in frequency, severity and duration of attacks since starting treatment? ❑ Yes ❑ No

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)**