



## Takhzyro

### 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.

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](mailto: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'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*

*Please indicate the place of service for the requested drug:*

- Ambulatory Surgical       Home       Off Campus Outpatient Hospital  
 On Campus Outpatient Hospital       Office       Pharmacy

**Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-855-330-1720**

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received the fax in error, please immediately notify the sender by telephone and destroy the original fax message. Takhzyro SGM – 11/2020.

**CVS Caremark Specialty Pharmacy • 2211 Sanders Road NBT-6 • Northbrook, IL 60062**  
**Phone: 1-888-877-0518 • Fax: 1-855-330-1720 • www.caremark.com**

**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 Takhzyro being used for the prevention of HAE attacks?  Yes  No
4. How many HAE attacks does the patient have per month? \_\_\_\_\_ attacks
5. Will Takhzyro be used in combination with Haegarda or Cinryze?  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.  $\geq 50\%$ ) 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
9. Is Takhzyro being dosed every 4 weeks? *If Yes, skip to diagnosis section*  Yes  No
10. Is the member stable on current dosing regimen?  Yes  No *If No, skip to diagnosis section*
11. Has dosing every 4 weeks been considered?  Yes  No

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

**Section A: Hereditary Angioedema (HAE) with C1 Inhibitor Deficiency or Dysfunction Confirmed by Laboratory Testing**

12. 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
13. 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**

14. 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, angiotensin-1, plasminogen, or kininogen-1 (KNG1) gene mutation testing or chart notes confirming family history of angioedema.***  
 F12, angiotensin-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 \_\_\_\_\_

**Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-855-330-1720**

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received the fax in error, please immediately notify the sender by telephone and destroy the original fax message. Takhzyro SGM – 11/2020.

**CVS Caremark Specialty Pharmacy • 2211 Sanders Road NBT-6 • Northbrook, IL 60062  
Phone: 1-888-877-0518 • Fax: 1-855-330-1720 • www.caremark.com**

*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**

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received the fax in error, please immediately notify the sender by telephone and destroy the original fax message. Takhyro SGM – 11/2020.

**CVS Caremark Specialty Pharmacy • 2211 Sanders Road NBT-6 • Northbrook, IL 60062**

**Phone: 1-888-877-0518 • Fax: 1-855-330-1720 • [www.caremark.com](http://www.caremark.com)**