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. 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:** ___________________

<u>Referring</u> Provider Info: ❑ **Same as Requesting Provider**
Name: ____ **NPI#:** ______________________________
Fax: ________________________ **Phone:** _____________________

<u>Rendering</u> 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.

<u>Required Demographic Information:</u>

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*

<u>Clinical Criteria Questions:</u>

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 the requested medication being used for the prevention of HAE attacks? ❑ Yes ❑ No
4. How many HAE attacks does the patient have per month? ________ attacks
5. Will the requested medication be used in combination with any other medication used for the prophylaxis of HAE attacks? ❑ Yes ❑ No

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

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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. >= 50%) since starting treatment? ***ACTION REQUIRED: If "Yes", please 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 the requested medication being dosed every 4 weeks? *If Yes, skip to diagnosis section* ☐ Yes ☐ No

10. Has the patient been well-controlled on therapy for 6 months? ☐ 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 test prior to initiating therapy (i.e. testing at the time of diagnosis and/or prior to starting any biologic treatment? ***ACTION REQUIRED: If 'Yes', please attach laboratory test or medical record documentation confirming low C4 level.*** ☐ Yes ☐ No ☐ Unknown

13. Which of the following conditions does the patient have? ***ACTION REQUIRED: For any answer, please 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, angiopoietin-1, plasminogen, kininogen-1 (KNG1), heparan sulfate-glucosamine 3-O-sulfotransferase 6 (HS3ST6), or myoferlin (MYOF) gene mutation testing or chart notes confirming family history of angioedema.***
   ☐ F12, angiopoietin-1, plasminogen, kininogen-1 (KNG1), heparan sulfate-glucosamine 3-O-sulfotransferase 6 (HS3ST6), or myoferlin (MYOF) gene mutation as confirmed by genetic testing
   ☐ BOTH of the following: 1) Angioedema refractory to a trial of high-dose antihistamine therapy (i.e., cetirizine at 40 mg per day or the equivalent) for at least one month AND 2) Family history of angioedema
   ☐ 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)**

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