Berinert, Cinryze (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's Name: _____ **Date**: _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____

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*

Criteria Questions:

1. What is the pateint's diagnosis? ***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, *skip to #3*
   - ❑ HAE with normal C1 inhibitor confirmed by laboratory testing
   - ❑ Other _____
2. 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 _____
3. ICD-10: _____
4. Would the prescriber like to request an override of the step therapy requirement? ❑ Yes ❑ No *If No, skip to #7*
5. Has the member received the medication through a pharmacy or medical benefit within the past 180 days? ❑ Yes ❑ No ***ACTION REQUIRED: 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.)***
6. Is the medication effective in treating the member's condition? ❑ Yes ❑ No *Continue to #7 and complete this form in its entirety.*

7. What is the prescribed drug? ❑ Cinryze *If Cinryze, skip to #16* ❑ Berinert
8. The preferred product for your patient's health plan is Ruconest. Can the patient's treatment be switched to Ruconest? ❑ Yes *If Yes, Please obtain Ruconest PA Form* ❑ No
9. Is this request for continuation of therapy with the requested product? ❑ Yes, *skip to #15* ❑ No
10. Is the patient currently receiving the requested product through samples or a manufacturer's patient assistance program? ❑ Yes ❑ No, *skip to #15*
11. Has the patient tried and experienced an inadequate response to Ruconest? ❑ Yes, *skip to #15* ❑ No
12. Has the patient tried and experienced an intolerable adverse event to Ruconest❑ Yes, *skip to #15* ❑ No
13. Does the patient have a contraindication to Ruconest (i.e., a known or suspected allergy to rabbits or rabbit-derived products)? ❑ Yes, *skip to #15* ❑ No
14. Is Berinert being requested for the treatment of laryngeal attacks? ❑ Yes ❑ No
15. Is Berinert being used for the treatment of acute HAE attacks? ❑ Yes ❑ No *Skip to #19*
16. Is Cinryze being used for the prevention of future HAE attacks? ❑ Yes ❑ No
17. Has the patient experienced an inadequate response or intolerance to danazol? *If Yes, skip to #19* ❑ Yes ❑ No
18. Does the patient have a clinical reason to avoid danazol? ❑ Yes ❑ No
    If Yes, please indicate: _____
19. Is the patient currently receiving treatment with the requested product? ❑ Yes ❑ No *If No, no further questions.*
20. 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)**