Berinert

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 1-866-249-6155**. 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: _____
Request Initiated For: _____

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 product being requested for the treatment of acute attacks of hereditary angioedema?
   ❑ Yes ❑ No *If No, skip to #8*
4. The preferred products for your patient's health plan are Firazyr and Ruconest. Can the patient's treatment be switched to Firazyr or Ruconest?
   ❑ Yes - Please specify: _____ ***If Yes, please call 1-866-814-5506 to have the updated form faxed to your office OR you may complete the PA electronically (ePA). You may sign up online via CoverMyMeds at: www.covermymeds.com/epa/caremark/ or call 1-866-452-5017.***
   ❑ No - Continue request for Berinert
5. Is Berinert being requested for the treatment of laryngeal attacks? ❑ Yes ❑ No
6. *If patient is 13 years or older but less than 18 years of age,* does the patient have a contraindication to Ruconest (i.e., a known or suspected allergy to rabbits or rabbit-derived products)? ***ACTION REQUIRED: If Yes, attach supporting chart note(s).*** ❑ Yes ❑ No ❑ Not applicable - patient is less than 13 years of age, *skip to #8.*
7. Does the patient have a documented inadequate response, intolerable adverse event and/or contraindication to treatment with the any of the preferred products? ***ACTION REQUIRED: If Yes, attach supporting chart note(s).*** *Indicate ALL that apply.*
   ❑ Firazyr ❑ Inadequate response ❑ Intolerable adverse event ❑ Contraindication
   ❑ Ruconest ❑ Inadequate response ❑ Intolerable adverse event ❑ Contraindication
   ❑ No - none of the above, *complete this form in its entirety and State Step Therapy section.*
8. Is Berinert being used for the treatment of acute HAE attacks? ❑ Yes ❑ No
9. Will Berinert be used with Firazyr, Kalbitor or Ruconest? ❑ Yes ❑ No

Send completed form to: Case Review Unit, CVS Caremark Prior Authorization Fax: 1-866-249-6155

 Berinert State Step, ACSF SGM -12/2020.

10. Has the patient received treatment with the requested medication? ❑ Yes ❑ No *If No, skip to #12*

11. Has the patient experienced reduction in severity and/or duration of attacks since starting treatment?
❑ Yes ❑ No

12. What is the patient's body weight? _____ kg or lbs ***(Circle one)***

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

13. 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 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: Based on the answer provided, attach genetic test or medical record documentation confirming F12, angiopoietin-1 or plasminogen gene mutation testing or chart notes confirming family history of angioedema.***
❑ 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) for at least one month
❑ Other _____ (Firazyr or Ruconest)

State Step Therapy

1. Is the requested drug being used for an FDA-approved indication or an indication supported in the compendia of current literature (examples: AHFS, Lexicomp, Clinical Pharmacology, Micromedex, current accepted guidelines)?
❑ Yes ❑ No

2. Does the prescribed quantity fall within the manufacturer's published dosing guidelines or within dosing guidelines found in the compendia of current literature (examples: package insert, AHFS, Lexicomp, Clinical Pharmacology, Micromedex, current accepted guidelines)? ❑ Yes ❑ No

3. Does the patient reside in Maryland? ❑ Yes ❑ No *If No, skip to #7*

4. Is the alternate drug (Firazyr or Ruconest) FDA-approved for the medical condition being treated?
❑ Yes ❑ No *If No, please specify:* _____

5. Has the prescriber provided proof, documented in the patient's chart notes, indicating that the requested drug was ordered for the patient in the past 180 days? ❑ Yes ❑ No *If No, skip to #7*

6. Has the prescriber provided proof, documented in the patient chart notes, that in their opinion the requested drug is effective for the patient's condition? ❑ Yes ❑ No *No further questions*

7. Are any of the following conditions met for the alternate drug (Firazyr or Ruconest)?
❑ The alternate drug is contraindicated
❑ The alternate drug is likely to cause an adverse reaction, physical or mental harm
❑ The alternate drug is expected to be ineffective
❑ The alternate drug was previously tried or a drug in the same class or with the same action was previously tried and was stopped due to ineffectiveness or an adverse event
❑ The alternate drug is not in the patient's best interest
❑ The alternate drug was tried while covered by the current or the previous health benefit plan
❑ None of the above
If Yes, please specify: _____

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8. Is the patient stable or currently receiving a positive therapeutic outcome with the requested drug and a change in the prescription drug is expected to be ineffective or cause harm to the patient? ❑ 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)**

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