CVS caremark™ {{PANUMCODE}}

Cinryze

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.

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Patient's Name: {{MEMFIRST}} {{MEMLAST}} **Date**: {{TODAY}}
Patient's ID: {{MEMBERID}} **Patient's Date of Birth:** {{MEMBERDOB}}
Physician's Name: {{PHYFIRST}} {{PHYLAST}}
Specialty: _____, NPI#: _____
Physician Office Telephone: {{PHYSICIANPHONE}} **Physician Office Fax:** {{PHYSICIANFAX}}
Request Initiated For: {{DRUGNAME}}

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 Cinryze being used for the prevention of HAE attacks? ❑ Yes ❑ No
4. How many HAE attacks does the patient have per month? _____
5. Will Cinryze be used in combination with any other medication used for the prophylaxis of HAE attacks?
   ❑ 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. greater than or equal to 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

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

Section A: HAE with C1 Inhibitor Deficiency or Dysfunction Confirmed by Laboratory Testing

9. 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

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10. 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

11. 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, or kininogen-1 (KNG1) gene mutation testing or chart notes confirming family history of angioedema.***
    ❑ F12, angiopoietin-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 _____

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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