CareFirst
The CareFirst BlueCross BlueShield family of health care plans

Hereditary Angioedema – Prior Authorization Request

Send completed form to: Case Review Unit CVS/caremark Specialty Programs Fax: 866-249-6155

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 866-249-6155**. If you have questions regarding the prior authorization, please contact CVS/caremark at **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® 800-237-2767.

Patient Name:	**Date:**
Patient's ID:	**Patient's Date of Birth:**
Physician's Name:	
Specialty:	**NPI#:**
Physician Office Telephone:	**Physician Office Fax:**

1. What drug is being prescribed?
   ☐ Berinert® ☐ Cinryze® ☐ Firazyr® ☐ Kalbitor® ☐ Ruconest® ☐ Other ___________________________

2. What is the patient's diagnosis?
   ☐ Hereditary angioedema (HAE)
   ☐ Other ____

3. What is the ICD code? _____________

4. What is the patient's age? _____________ years

5. Has the diagnosis of HAE been confirmed by laboratory testing?
   ☐ Yes ☐ No ***Action Required*: Attach C4 levels, C1 inhibitor functional and antigenic protein levels.**

Complete the following questions based on the prescribed agent.

Section A: Firazyr®, Kalbitor®, or Ruconest®

6. Is the prescribed medication being used for treatment of acute HAE attacks? ☐ Yes ☐ No

Section B: Ruconest®

7. Does the patient have a known or suspected allergy to rabbits or rabbit-derived products? ☐ Yes ☐ No

8. Does the patient have a history of immediate hypersensitivity reactions to C1 esterase inhibitor preparations (eg, Cinryze®, Berinert®)? ☐ 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)**

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. Hereditary Angioedema SGM – 9/2014

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