Firazyr

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: _____

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1. What drug is being prescribed? ❑ Firazyr ❑ icatibant
2. 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 _____
3. What is the ICD-10 code? _____
4. Is the requested medication being used for the treatment of acute HAE attacks? ❑ Yes ❑ No
5. Will the requested medication be used in combination with Berinert, Kalbitor, or Ruconest? ❑ Yes ❑ No
6. Has the patient received treatment with the requested medication?
   ❑ Yes ❑ No *If No, skip to diagnosis section.*
7. Has the patient experienced reduction in severity and/or duration of attacks since starting treatment?
   ❑ 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

8. 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 _____

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

 Firazyr [icatibant] SGM - 10/2019.

Section B: HAE with Normal C1 Inhibitor

9. 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 _____

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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