Cinryze

Prior Authorization Request

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

CVS Caremark administers the prescription benefit plan for the member 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.

PATIENT INFORMATION

Date: _____
Name: _____
ID: _____
Date of Birth: _____
Request Initiated For: _____

PRESCRIBER INFORMATION

Name: _____
Office Telephone: _____
Office Fax: _____
Specialty: _____
NPI#: _____

PATIENT DIAGNOSIS & ICD-10 CODE

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
❑ HAE with normal C1 inhibitor confirmed by laboratory testing
❑ Other _____

ICD-10: _____

DIAGNOSIS SPECIFIC QUESTIONS

All Diagnoses

1. Is Cinryze being used for the prevention of future HAE attacks? ❑ Yes ❑ No
2. Has the patient experienced an inadequate response or intolerance to danazol? *If Yes, skip to #4* ❑ Yes ❑ No
3. Does the patient have a clinical reason to avoid danazol? ❑ Yes ❑ No
   If Yes, please indicate: _____
4. Is the patient currently receiving treatment with Cinryze? ❑ Yes ❑ No *If No, no furher questions.*
5. Has the patient experienced reduction in frequency, severity, and duration of attacks since starting treatment?
   ❑ Yes ❑ No

HAE with Normal C1 Inhibitor Confirmed by Laboratory Testing

1. 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 _____

AUTHORIZATION

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)**