



Ruconest

HMSA Medicare Advantage - 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 1-866-237-5512.** If you have questions regarding the prior authorization, please contact CVS Caremark at **1-808-254-4414**. 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: _____ **Date:** _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Patient's Phone Number: _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Additional Demographic Information:

Patient Weight: _____ kg
Patient Height: _____ ft _____ inches

Indicate where the drug is being dispensed:

- Office Outpatient Hospital Ambulatory Surgical Inpatient Hospital
- Off Campus Outpatient Hospital Urgent Care Emergency Room Birthing Center
- Military Facility Skilled Nursing Facility Nursing Facility Hospice
- Inpatient Psychiatric Psychiatric Residential Treatment End Stage Renal Facility
- Psychiatric Facility Pharmacy Other

Indicate where the drug is being administered:

- Ambulatory surgical Home Inpatient Hospital
- Office Outpatient Hospital Pharmacy

What is the ICD-10 code? _____

Send completed form to: CVS Caremark Specialty Programs. Fax: 1-866-237-5512

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Criteria Questions:

1. What is the diagnosis?

- Hereditary angioedema (HAE) with C1 inhibitor deficiency or dysfunction confirmed by laboratory testing, *Continue to #2*
- Hereditary angioedema (HAE) with normal C1 inhibitor confirmed by laboratory testing, *Continue to #2*
- Other, *No Further Questions*

2. Is the requested medication being used for the treatment of acute hereditary angioedema (HAE) attacks?

- Yes, *Continue to #3*
- No, *Continue to #3*

Continuation

3. Is the patient currently receiving therapy with the requested medication?

- Yes, *Continue to #4*
- No, *Continue to #10*

4. Is the patient receiving benefit from therapy which is defined as a reduction in severity and/or duration of acute attacks? ***If yes, chart notes demonstrating a reduction in severity and/or duration of acute attacks must be available upon request***

- Yes, *No Further Questions*
- No, *No Further Questions*

Initial

10. What is the diagnosis?

- Hereditary angioedema (HAE) with C1 inhibitor deficiency or dysfunction confirmed by laboratory testing, *Continue to #11*
- Hereditary angioedema (HAE) with normal C1 inhibitor confirmed by laboratory testing, *Continue to #12*

11. Which of the following conditions does the patient have at the time of diagnosis? ***For any answer, laboratory test or medical record documentation confirming C1 inhibitor functional and antigenic protein levels must be available upon request***

- A C1 inhibitor (C1-INH) antigenic level below the lower limit of normal as defined by the laboratory performing the test, *No Further Questions*
- 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), *No Further Questions*
- Other, *No Further Questions*

12. Which of the following conditions does the patient have at the time of diagnosis? ***For any answer, laboratory test or medical record documentation confirming normal C1 inhibitor must be available upon request. Based on the answer provided, genetic test or medical record documentation confirming F12, angiopoietin-1, plasminogen, kininogen-1 (KNG1), heparan sulfate-glucosamine 3-O-sulfotransferase 6 (HS3ST6), or myoferlin (MYOF) gene mutation testing or chart notes confirming family history of angioedema and the angioedema was refractory to a trial of high-dose antihistamine therapy must be available upon request***

- F12, angiopoietin-1, plasminogen, kininogen-1 (KNG1), heparan sulfate-glucosamine 3-O-sulfotransferase 6 (HS3ST6), or myoferlin (MYOF) gene mutation as confirmed by genetic testing, *No Further Questions*

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- BOTH of the following: 1) Angioedema refractory to a trial of high-dose antihistamine therapy (i.e., cetirizine at 40 mg per day or the equivalent) for one month or longer AND 2) Family history of angioedema, *No Further Questions*
- 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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