Cinryze

Prior Authorization Request

Your patient's benefit plan requires prior authorization for certain medications. In order to make appropriate medical necessity determinations, your patient's diagnosis and other clinical information is required. **Please complete the information requested on the form below and fax this form along with supporting clinical documentation to Priority Partners, toll-free at 1-866-212-4756 to initiate the review process.** If you have questions regarding the prior authorization please contact Priority Partners at 888-819-1043 Option 4**.**

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

Referring Provider Info: ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Rendering Provider Info: ❑ **Same as Referring Provider** ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

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

Required Demographic Information:

Patient Weight: _____*kg*

*Patient Height:*_____*cm*

Please indicate the place of service for the requested drug:

❑ *Ambulatory Surgical* ❑ *Home* ❑ *Off Campus Outpatient Hospital*
❑ *On Campus Outpatient Hospital* ❑ *Office*

Drug Information:

*Strength/Measure*_____ *Units* ❑ ml ❑ Gm ❑ mg ❑ ea ❑ Un
*Directions(sig)*_____ *Route of administration*_____
*Dosing frequency*_____

Send completed form to: Priority Partners Fax: 1-866-212-4756

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. Cinryze SGM – 10/2021.

Priority Partners ● 7231 Parkway Drive Suite 100 ● Hanover, MD 21076
Phone: 888-819-1043 ● Fax: 1-866-212-4756 ● www.jhhc.com

Clinical Criteria Questions:

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 the requested medication being used for the prevention of HAE attacks? ❑ Yes ❑ No
4. How many HAE attacks does the patient have per month? _____ attacks
5. Will the requested medication 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. >= 50%) since starting treatment?
   ACTION REQUIRED: If "Yes", please 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 prior to initiating therapy (i.e. testing at the time of diagnosis and/or prior to starting any biologic treatment)?
   ACTION REQUIRED: If 'Yes', please attach laboratory test or medical record documentation confirming low C4 level. ❑ Yes ❑ No ❑ Unknown
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, please 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, 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.***
    - ❑ 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
    - ❑ 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 at least one month AND 2) Family history of angioedema
    - ❑ Other _____

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by Priority Partners.

X_____
Prescriber or Authorized Signature **Date (mm/dd/yy)**

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