Kalbitor

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 (POS Code 24)*
❑ *Home (POS Code 12)*
❑ *Off Campus Outpatient Hospital (POS Code 19)*
❑ *On Campus Outpatient Hospital (POS Code 22)*
❑ *Office (POS Code 11)*

Drug Information:

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

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 3*

❒ Other, please specify. _____, *No Further Questions*

2. Which of the following conditions does the patient have at the time of diagnosis? ***ACTION REQUIRED***: For any answer, attach laboratory test or medical record documentation confirming C1 inhibitor functional and antigenic protein levels.

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

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

❒ A C1 inhibitor (C1-INH) antigenic level below the lower limit of normal as defined by the laboratory performing the test ***ACTION REQUIRED****: Submit supporting documentation, Continue to 4*
❒ 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) ***ACTION REQUIRED****: Submit supporting documentation, Continue to 4*
❒ Other, please specify. _____ ***ACTION REQUIRED****: Submit supporting documentation, Continue to 4*

3. Which of the following conditions does the patient have at the time of diagnosis? ***ACTION REQUIRED***: For any answer, attach laboratory test or medical record documentation confirming 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 and the angioedema was refractory to a trial of high-dose antihistamine therapy.
❒ 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 ***ACTION REQUIRED****: Submit supporting documentation, Continue to 4*
❒ 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 ***ACTION REQUIRED****: Submit supporting documentation, Continue to 4*
❒ Other, please specify. _____ ***ACTION REQUIRED****: Submit supporting documentation, Continue to 4*

4. Is the requested medication being used for the treatment of acute hereditary angioedema (HAE) attacks?
❒ Yes, *Continue to 5*
❒ No, *Continue to 5*

5. Will the requested medication be used in combination with any other medication used for the treatment of acute hereditary angioedema (HAE) attacks (e.g., Berinert, Firazyr, Ruconest)?
❒ Yes, *Continue to 6*
❒ No, *Continue to 6*

6. Is the requested medication prescribed by or in consultation with a prescriber who specializes in the management of hereditary angioedema (HAE)?
❒ Yes, *Continue to 7*
❒ No, *Continue to 7*

7. Has the patient previously received treatment with the requested medication?
❒ Yes, *Continue to 8*
❒ No, *No Further Questions*

8. Has the patient experienced a reduction in severity and/or duration of acute attacks? ***ACTION REQUIRED***: If Yes, attach supporting chart note(s) demonstrating a reduction in severity and/or duration of acute attacks.
❒ Yes, *Continue to 9*
❒ No, *Continue to 9*

9. Does the patient's attack frequency, attack severity, comorbid conditions and patient's quality of life warrant prophylactic therapy?
❒ Yes, *Continue to 10*
❒ No, *No Further Questions*

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10. Has prophylactic treatment been considered?
❒ Yes, *No Further Questions*
❒ No, *Continue to 11*

11. Please provide a brief rationale as to why prophylactic treatment has not been considered.
❒ _____, *No Further Questions*
❒ Unknown, *No Further Questions*

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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