Drug Prior Authorization FAX form

Please allow 3 business days for review of this request

Berinert®, Cinryze®, Firazyr®, Ruconest®
For self-administration

HAE

Please complete and fax this form to:

Specialty medications can be filled at:

FLRx Pharmacy Help Desk
Fax #: 1-800-956-2397
Phone #: 1-800-724-5033

Accredo Health
Fax #: 1-888-773-7386
Phone #: 1-866-413-4137

Walgreens Specialty Pharmacy
Fax#: 1-866-435-2173
Phone#: 1-866-435-2171

***Refer to Hereditary Angioedema (HAE) policy for complete policy criteria**

Please complete all of the following Patient/Physician information:

Patient Name: (Please Print)	**Patient Phone #:** (with area code)
List Patient Allergy (if any):	
Patient ID #:	**Patient Birthdate:**
MD Name:	**MD Specialty:**
MD Provider Number:	**MD Phone #:**
MD DEA #:	**MD FAX #:**
MD NPI #:	
Medication Shipping address:	

QUESTIONS / INDICATIONS FOR MEDICAL NECESSITY:		
Drug:	**Directions:**	**Qty:**
☐ **Berinert 500 units**	**20 units per kg administered IV. Infuse 4 ml/minute. Pt weight:_______kg**	**#_____(500 unit vials)**
☐ **Cinryze 1000 units**	**1000 units IV q 3-4 days. Infuse 1 ml/min over 10min**	**#_____(500 unit vials)**
☐ **Firazyr 30mg/3ml**	**30mg subcutaneously for a maximum of 3 doses within 24 hours**	**#_____(3ml single use syringes)**
☐ **Ruconest 2100 units**	**50 units per kg as a single IV dose for patients weighing less than 84kg OR 4200 units as a single IV dose in patients weighing 84kg or more. Slow IV injection over approx. 5 minutes Pt weight:_______kg**	**#_____(2100 unit vials)**

1. Does the patient have documented hereditary angioedema based on 2 separate measurements indicating decreased quantities of C4 and C1-INH? ☐ **YES** ☐ **NO**
PLEASE SUPPLY LAB REPORTS AND PROGRESS NOTES WITH ALL REQUESTS

2. Is therapy being requested for: ☐ **New Start** ☐ **Recertification** ☐ **Prophylaxis** ☐ **Acute treatment**

3. Is the prescribing physician a:
☐ **Dermatologist** ☐ **Hematologist** ☐ **Allergist/Immunologist** ☐ **Other ____________________**

4. Will treatment be administered by the patient or caregiver? ☐ **YES** ☐ **NO**

5. Where will treatment be administered? ☐ **Home** ☐ **Office/Infusion Center**

6. Has this patient had at least 2 severe attacks per month? ☐ **YES** ☐ **NO**

7. Is the patient using any other medications for the treatment of HAE concurrently? ☐ **YES** ☐ **NO**
(If yes, then please list other medications)____________________________________

8. For Cinryze, has pt had trial or contraindication to: ☐**Aminocaproic Acid** ☐**Danazol** ☐**Tranexamic Acid**

Other Comments/Justification:

I certify that the above information is true and accurate to the best of my knowledge.

Prescriber Signature: **Date:**

Urgent Requests Only: 1-800-208-4050 (fax)