Excellus

Specialty Medication Review Program

Berinert®, Cinryze®, Firazyr®, Icatibant®, Haegarda®, Kalbitor®, Orladeyo®, Ruconest®, Sajazir®, Takhzyro®
for **HAE**
(Self-Administration) Rx Benefit

Complete this form and fax to:

Medical Specialty Unit
Fax #: 1-800-306-0188
Phone #: 1-800-306-0151

If you are not **buying and billing** this medication, indicate which specialty pharmacy will be used:

☐ **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

Complete ALL the following Patient/Prescriber Information: (Please Print)

Patient Information	
Patient Name:	Patient Phone #: ( )
Patient ID #:	Patient Birthdate:
List Patient Allergy (If Any)	
Prescriber Information	
Prescriber Name:	Prescriber Specialty:
Prescriber Address:	
Prescriber Phone #:	Prescriber Fax #:
Prescriber NPI #:	Office Contact: Extension:

Location of Infusion:
☐ **Prescriber office** ☐ **Home/Homecare agency:**_____
☐ **Outpatient facility** ☐ **Other:** _____

Servicing Prescriber NPI (if different from the ordering prescriber):

Provide address of infusion location above for medication shipping:

1. **Medication/Medical and Dispensing Information (Select which medication you are requesting below)**

Medication	Dose & Frequency	Quantity per month
☐ Berinert 500 units (J0597)	20 units per kg administered IV. Infuse 4 ml/minute. Patient's weight: _____	#____ (500-unit vials)
☐ Cinryze 500 units (J0598)	_____ units IV q _____ days. Infusion rate: 1 ml/min	#____ (500-unit vials)
☐ Firazyr 30mg/3ml ☐ Icatibant 30mg/3ml ☐ Sajazir 30mg/3ml	30mg subcutaneously for a maximum of 3 doses within 24 hours	#____ (3ml single use syringes)
☐ Haegarda 2000 Unit ☐ Haegarda 3000 Unit	60 IU per kg subcutaneously twice weekly. Patient weight: _____ kg	#____ of vials
☐ Orladeyo 150mg capsule ☐ Orladeyo 110mg capsule	Take (1) one capsule by mouth daily with food	# 28 capsules per 28 days
☐ Ruconest 2100 Units (J0596)	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.	#____ (2100-unit vials)
☐ Takhzyro 300mg/2ml syringe (J0593) ☐ Takhzyro 300mg/2ml vial (J0593) ☐ Takhzyro 150mg/ml syringe (J0593)	30mg (3ml) administered SQ in three 10mg (1ml) injections. If needed, an additional 30mg dose may be administered within 24hrs	#____ (10mg/ml) (single use vials)

2. **Height** _____ 3. **Diagnosis/ICD-10:**_____ 4. **Procedure Code:**_____

5. **Is this request a:** ☐ New Start, ☐ Prophylaxis, ☐ Acute Treatment, ☐ Recertification/Continuation of Therapy Start Date: _____

6. Will treatment be administered by the ☐ Patient **OR** ☐ Caregiver?

Questions / Indications for Medical Necessity

****See the Hereditary Angioedema Policy (Pharmacy-19) for full Prior Authorization criteria****

1. Does the patient have a documented diagnosis of hereditary angioedema? *Please supply lab reports (C4, C1-INH Antigenic Protein and C1-INH Functional Level) **AND** *Progress Notes with ALL requests	☐ **Yes** ☐ **No**
2. Is the prescribing physician a: ☐ Dermatologist ☐ Hematologist ☐ Allergist/Immunologist ☐ Other: _____	☐ **Yes** ☐ **No**
3. Has this patient has at least one laryngeal attack or 2 severe attacks per month?	☐ **Yes** ☐ **No**
4. Is the patient using any other medications for the treatment of HAE concurrently? *If yes, please lists other medications below:	☐ **Yes** ☐ **No**

Drug Name	Dose	Frequency	Period of use	Outcome
			Start: End:	
			Start: End:	

5. For Cinryze, has the patient had a trial or contraindication to Haegarda **AND** Takhzyro?	☐ **Yes** ☐ **No**
6. For brand Firazyr, Has the patient had a trial or contraindication to generic Icatibant **OR** Sajazir	☐ **Yes** ☐ **No**

*Prescriber Signature: _____ Date: _____

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