Ruconest

CareFirst 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 1-855-330-1720**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-888-877-0518.** 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.

The recipient of this fax may make a request to opt-out of receiving telemarketing fax transmissions from CVS Caremark. There are numerous ways you may opt-out: The recipient may call the toll-free number at 877-265-2711, at any time, 24 hours a day/7 days a week. The recipient may also send an opt-out request via email to do_not_call@cvscaremark.com. An opt out request is only valid if it (1) identifies the number to which the request relates, and (2) if the person/entity making the request does not, subsequent to the request, provide express invitation or permission to CVS Caremark to send facsimile advertisements to such person/entity at that particular number. CVS Caremark is required by law to honor an opt-out request within thirty days of receipt.

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*	❑ *Pharmacy*

What is the ICD-10 code? _____

Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-855-330-1720

 Ruconest SGM 1612-A – 03/2025.

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.
❒ 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 inhibitor (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 treatment of acute hereditary angioedema (HAE) attacks (e.g., Berinert, Firazyr, Kalbitor)?
❒ Yes, *No Further Questions*
❒ No, *Continue to 6*

6. Have other causes of angioedema been ruled out (e.g., angiotensin-converting enzyme inhibitor [ACE-I] induced angioedema, angioedema related to an estrogen-containing drug, allergic angioedema)?
❒ Yes, *Continue to 7*
❒ No, *Continue to 7*

7. Is the requested medication being prescribed by or in consultation with a prescriber who specializes in the management of hereditary angioedema (HAE)?
❒ Yes, *Continue to 8*
❒ No, *Continue to 8*

8. Has the patient previously received treatment with the requested medication?

❒ Yes, *Continue to 9*
❒ No, *No Further Questions*

9. 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 10*
❒ No, *Continue to 10*

10. Does the patient's attack frequency, attack severity, comorbid conditions and patient's quality of life warrant prophylactic therapy?
❒ Yes, *Continue to 11*
❒ No, *No Further Questions*

11. Has prophylactic treatment been considered?
❒ Yes, *No Further Questions*
❒ No, *Continue to 12*

12. Please provide a brief rationale as to why prophylactic treatment has not been considered.
❒ Please specify rationale.
_____
_____, *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)**

Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-855-330-1720

CVS Caremark Specialty Pharmacy ● 2211 Sanders Road NBT-6 ● Northbrook, IL 60062
Phone: 1-888-877-0518 ● Fax: 1-855-330-1720 ● www.caremark.com