



Takhzyro

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.

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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

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. Takhzyro SGM 2668-A – 03/2025

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

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-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, angiotensin-converting enzyme inhibitor (ACE-I), plasminogen, kininogen-1 (KNG1), heparan sulfate-glucosaminase 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, angiotensin-converting enzyme inhibitor (ACE-I), plasminogen, kininogen-1 (KNG1), heparan sulfate-glucosaminase 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 prevention of hereditary angioedema (HAE) attacks?

☐ Yes, *Continue to 5*

☐ No, *Continue to 5*

5. How many hereditary angioedema (HAE) attacks does the patient have per month?

Please specify the number of attacks. _____, *Continue to 6*

☐ Unknown, *Continue to 6*

6. Will the requested medication be used in combination with any other medication used for the prophylaxis of hereditary angioedema (HAE) attacks?

☐ Yes, *Continue to 7*

☐ No, *Continue to 7*

7. 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 8*

☐ No, *Continue to 8*

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8. 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 9*

☐ No, *Continue to 9*

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

☐ Yes, *Continue to 10*

☐ No, *No Further Questions*

10. Has the patient experienced a significant reduction in frequency of attacks (e.g., greater than or equal to 50%) since starting treatment? **ACTION REQUIRED:** If Yes, attach chart notes demonstrating a reduction in the frequency of attacks.

☐ Yes, *Continue to 11*

☐ No, *Continue to 11*

11. Has the patient reduced the use of medications to treat acute attacks since starting treatment with the requested medication?

☐ Yes, *Continue to 12*

☐ No, *Continue to 12*

12. Is the requested medication being dosed every 4 weeks?

☐ Yes, *No Further Questions*

☐ No, *Continue to 13*

13. Has the patient been well-controlled on therapy for more than 6 months?

☐ Yes, *Continue to 14*

☐ No, *No Further Questions*

14. Has dosing every 4 weeks been considered?

☐ Yes, *No Further Questions*

☐ No, *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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