PA Request Criteria

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This fax machine is located in a secure location as required by HIPAA regulations. Fax complete signed and dated forms to CVS/Caremark at . Please contact CVS/Caremark at 1-888-413-2723 with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of the medication.

Patient Name: _____ **Date:** 3/31/2025
Patient ID: _____ **Patient Date Of Birth:** _____
Patient Group No: _____ **Patient Phone:** _____ **Physician Name:**
NPI#: **Specialty:**
Physician Office Address: _____ **Physician Office Telephone:**

Drug Name (specify drug) _____

Quantity: _____ **Frequency:** _____ **Strength:** _____

Route of Administration: _____ **Expected Length of Therapy:** _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

Please check the appropriate answer for each applicable question.

1. What is the diagnosis?

   - ☐ Hereditary angioedema (HAE) with C1 inhibitor deficiency or dysfunction confirmed by laboratory testing (If checked, go to 2)
   - ☐ Hereditary angioedema (HAE) with normal C1 inhibitor confirmed by laboratory testing (If checked, go to 3)
   - ☐ Other, please specify. (If checked, 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 (If checked, go 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) (If checked, go to 4)
   - ☐ Other, please specify. (If checked, no further questions)

   _____
   ACTION REQUIRED: Submit supporting documentation

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 (If checked, go 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 (If checked, go to 4)
   - ☐ Other, please specify. (If checked, no further questions)

   _____
   ACTION REQUIRED: Submit supporting documentation

4. Is the requested medication being used for the prevention of hereditary angioedema (HAE) attacks? **Y** ☐ **N** ☐

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

   Please specify the number of attacks. (If checked, go to 6) ☐

   _____

   Unknown (If checked, go to 6) ☐

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

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)? **Y** ☐ **N** ☐

8. Is the requested medication being prescribed by or in consultation with a prescriber who specializes in the management of hereditary angioedema (HAE)? **Y** ☐ **N** ☐

9. Has the patient previously received treatment with the requested medication? **Y** ☐ **N** ☐

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.
    ACTION REQUIRED: Submit supporting documentation **Y** ☐ **N** ☐

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

12. Is the requested medication being dosed every 4 weeks? **Y** ☐ **N** ☐

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

14. Has dosing every 4 weeks been considered? **Y** ☐ **N** ☐

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

_____

Prescriber (Or Authorized) Signature and Date