BlueCross BlueShield Federal Employee Program

RUCONEST
PRIOR APPROVAL REQUEST

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

Additional information is required to process your claim for prescription drugs. Please complete the cardholder portion, and have the prescribing physician complete the physician portion and submit this completed form.

Patient Information (required)			**Provider Information (required)**		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		
PHYSICIAN COMPLETES					

Ruconest

(C1 esterase inhibitor [recombinant])

NOTE: Form must be completed in its **entirety** for processing

Is this request for brand or generic? ❑Brand ❑Generic

1. What is the patient's diagnosis?
   - ❑ Hereditary Angioedema (HAE)
   - ❑ Other diagnosis (***please specify***): _____
2. Is Ruconest being used to treat acute attacks or for the routine prevention of hereditary angioedema? ***Please select answer below:***
   ❑Acute attacks **OR** ❑Routine prevention
3. Is Ruconest being used to treat laryngeal attacks? ❑Yes ❑No
4. Will the patient also be using another agent for treating **ACUTE** attacks of hereditary angioedema (e.g., Berinert, Firazyr/Sajazir, Kalbitor)? ❑Yes***** ❑No
   ****If YES***, specify the medication: _____
5. Has the patient been on Ruconest continuously for the last **6 months**, excluding samples? ***Please select answer below:***

❑**NO** – this is **INITIATION** of therapy, please answer the following questions:

a. Does the patient have a normal C1 inhibitor as confirmed by laboratory testing? ***Select answer below:***

❑**Yes**: Please answer the following questions:

i. Does the patient have a F12, angiopoietin-1, plasminogen, or kininogen-1 (KNG1) gene mutation as confirmed by genetic testing? ❑Yes ❑No

ii. Does the patient have a documented family history of angioedema? ❑Yes***** ❑No

****If YES***, is the angioedema refractory to a trial of high-dose antihistamine such as cetirizine for at least one month? ❑Yes ❑No

❑**No**: Please answer the following questions:

i. Does the patient have a C1inhibitor deficiency or dysfunction as confirmed by laboratory testing? ❑Yes ❑No

ii. Is the patient's C4 level below the lower limit of normal as defined by the laboratory performing the test? ❑Yes ❑No

iii. Does the patient have a normal C1-INH antigenic level as defined by the laboratory performing the test? ***Answer below:***

❑**Yes**: Does the patient have a C1-INH functional level less than 50% or a C1-INH functional level below the lower limit of normal as defined by the laboratory performing the test? ❑Yes ❑No

❑**No**: Is the patient's C1 inhibitor (C1-INH) antigenic level below the lower limit of normal as defined by the laboratory performing the test? ❑Yes ❑No

❑**YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the following question:

a. Has the patient experienced a reduction in severity and/or duration of hereditary angioedema attacks? ❑Yes ❑No

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Message:

Attached is a Prior Authorization request form.

For your convenience, there are 3 ways to complete a Prior Authorization request:

Electronically Online (ePA) Results in 2-3 **minutes** **FASTEST AND EASIEST**	Now you can get responses to drug Prior Authorization requests **securely** online. **Online** submissions may receive **instant** responses and do not require faxing or phone calls. Requests can be made 24 hours a day, 7 days a week. For more information on electronic prior authorization (ePA) and to register, go to **Caremark.com/ePA.**
Phone (4-5 **minutes** for response)	The FEP Clinical Call Center can be reached at **(877)-727-3784** between the hours of 7AM-9PM Eastern Time. A live representative will assist with the Prior Authorization, asking for the same information contained on the attached form. Please review the form and have your answers ready for faster service. The process over the phone takes on average between 4 and 5 minutes.
Fax (3-5 **days** for response)	Fax the attached form to **(877)-378-4727**. Requests sent via fax will be processed and responded to within 5 business days. The form must be filled out completely, if there is any missing information the Prior Authorization request cannot be processed. ***Please only fax the completed form once as duplicate submissions may delay processing times.***

The information provided on this form will be used to determine the provision of healthcare benefits under a U.S. federal government program, and any falsification of records may subject the provider to prosecution, either civilly or criminally, under the False Claim Acts, the False Statements Act, the mail or wire fraud statutes, or other federal or state laws prohibiting such falsification. **Prescriber Certification:** I certify all information provided on this form to be true and correct to the best of my knowledge and belief. I understand that the insurer may request a medical record if the information provided herein is not sufficient to make a benefit determination or requires clarification and I agree to provide any such information to the insurer. Ruconest – FEP MD Fax Form Revised 10/8/2021