BlueCross BlueShield Federal Employee Program

ICATIBANT
PRIOR APPROVAL REQUEST

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

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

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

For Standard Option patients GENERIC Firazyr (icatibant) and Sajazir are the preferred products.
Standard Option patients who switch to generic Firazyr or Sajazir will be eligible for 2 copays at no cost in the benefit year.

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

Please select medication: ❑**Firazyr (icatibant)** ❑**Sajazir (icatibant)**

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

1. Has the patient been on this medication continuously for the last **6 months**, excluding samples? ***Please select answer below:***
   - ❑ **YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the questions on **PAGE 3**
   - ❑ **NO –** this is **INITIATION** of therapy, please answer the questions below:
2. Is this request for brand or generic? ❑ Brand ❑ Generic
3. **BRAND Firazyr Request (Standard Option)**: Would you like to switch the patient to a preferred product, **GENERIC** Firazyr (icatibant) or Sajazir? ❑Yes, switch to **generic** Firazyr (icatibant) ❑Yes, switch to Sajazir ❑No, do not switch*****
   ****If NO***, does the patient have an intolerance or contraindication to or have they had an inadequate treatment response to **generic** Firazyr (icatibant) or Sajazir? ***Please select answer below:***
   - ❑**Yes**, specify drug and result: _____
   - ❑**No**: Is there a clinical reason for not trying **generic** Firazyr (icatibant) or Sajazir? ❑Yes***** ❑No
     ****If YES***, please specify: _____
4. What is the patient's diagnosis?
   ❑Hereditary Angioedema (HAE) ❑Other diagnosis ***(please specify)***: _____
5. Is this medication being used to treat acute attacks or for the routine prevention of hereditary angioedema? ***Select answer below:***
   ❑Acute attacks **OR** ❑Routine prevention
6. Does the patient have a normal C1 inhibitor as confirmed by laboratory testing? ***Select answer below:***
   - ❑**Yes**: Please answer the following questions:
     a. Does the patient have a F12, angiopoietin-1, plasminogen, or kininogen-1 (KNG1) gene mutation as confirmed by genetic testing? ❑Yes ❑No
     b. Does the patient have a documented family history of angioedema? ❑Yes***** ❑No
     ****If YES***, was 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:
     a. Does the patient have a C1 inhibitor deficiency or dysfunction as confirmed by laboratory testing? ❑Yes ❑No
     b. Is the patient's C4 level below the lower limit of normal as defined by the laboratory performing the test? ❑Yes ❑No
     c. Does the patient have a normal C1-INH antigenic level as defined by the laboratory performing the test?
     - ❑**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

PLEASE PROCEED TO PAGE 2 FOR ADDITIONAL INITIATION QUESTIONS

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PAGE 2 - PHYSICIAN COMPLETES

Patient Name: _____ DOB: _____ Patient ID: R _____

7. Will this medication be used in combination with another agent for treating acute attacks of hereditary angioedema (e.g., Berinert, Kalbitor, Ruconest)? ❑Yes***** ❑No

   ****If YES***, specify the medication: _____

8. Is this medication being requested as a change from **BRAND** Firazyr so the member can access their copay benefit? ❑Yes ❑No

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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					

For Standard Option patients GENERIC Firazyr (icatibant) and Sajazir are the preferred products.
Standard Option patients who switch to generic Firazyr or Sajazir will be eligible for 2 copays at no cost in the benefit year.

CONTINUATION OF THERAPY (PA RENEWAL)

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

Please select medication: ❑**Firazyr (icatibant)** ❑**Sajazir (icatibant)**

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

1. Has the patient been on this medication continuously for the last **6 months**, excluding samples? ***Please select answer below:***
   ❑**NO –** this is **INITIATION** of therapy, please answer the questions on **PAGE 1**
   ❑**YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the questions below:

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

3. **BRAND Firazyr Request (Standard Option)**: Would you like to switch the patient to a preferred product **GENERIC** Firazyr (icatibant) or Sajazir? ❑Yes, switch to **generic** Firazyr (icatibant) ❑Yes, switch to Sajazir ❑No, do not switch*****
   If NO, does the patient have an intolerance or contraindication to or have they had an inadequate treatment response to **generic** Firazyr (icatibant) or Sajazir? ***Please select answer below:***
   ❑**Yes**, specify drug and result: _____
   ❑**No**: Is there a clinical reason for not trying **generic** Firazyr (icatibant) or Sajazir? ❑Yes***** ❑No
   If YES, please specify: _____

4. What is the patient's diagnosis?
   ❑Hereditary Angioedema (HAE)
   ❑Other diagnosis ***(please specify)***: _____

5. Is this medication being used to treat acute attacks or for the routine prevention of hereditary angioedema? ***Select answer below:***
   ❑Acute attacks **OR** ❑Routine prevention

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

7. Will this medication be used in combination with another agent for treating acute attacks of hereditary angioedema (e.g., Berinert, Kalbitor, Ruconest)? ❑Yes***** ❑No
   If YES, specify the medication: _____

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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. Icatibant – FEP MD Fax Form Revised 10/8/2021