Hereditary Angioedema Injectable Medication Precertification Request

(All fields must be completed and legible for Precertification Review.)

Aetna Precertification Notification
503 Sunport Lane, Orlando, FL 32809
Phone: 1-866-503-0857
FAX: 1-888-267-3277

For Medicare Advantage Part B:
FAX: 1-844-268-7263

Please indicate: ☐ Start of treatment: Start date ____/____/____
☐ Continuation of therapy: Date of last treatment ____/____/____

Precertification Requested By: ______________________ Phone: __________ Fax: __________

A. PATIENT INFORMATION

First Name: | Last Name:
Address: | City: | State: | ZIP:
Home Phone: | Work Phone: | Cell Phone:
DOB: | Allergies: | Email:
Current Weight: ______ lbs or ______ kgs Height: ______ inches or ______ cms

B. INSURANCE INFORMATION

Aetna Member ID #: ______________
Group #: ______________
Insured: ______________

Does patient have other coverage? ☐ Yes ☐ No
If yes, provide ID#: __________ Carrier Name: __________
Insured: ______________

Medicare: ☐ Yes ☐ No If yes, provide ID #: __________ **Medicaid**: ☐ Yes ☐ No If yes, provide ID #: __________

C. PRESCRIBER INFORMATION

First Name: | Last Name: | *(Check One)*: ☐ M.D. ☐ D.O. ☐ N.P. ☐ P.A.
Address: | City: | State: | ZIP:
Phone: | Fax: | St Lic #: | NPI #: | DEA #: | UPIN:
Provider Email: | Office Contact Name: | Phone:
Specialty *(Check one)*: ☐ **Allergist** ☐ **Immunologist** ☐ **Other**: ______________

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration:
☐ Self-administered ☐ Physician's Office
☐ Outpatient Infusion Center Phone: __________
Center Name: __________
☐ Home Infusion Center Phone: __________
Agency Name: __________
☐ Administration code(s) (CPT): __________
Address: __________

Dispensing Provider/Pharmacy: *Patient Selected choice*
☐ Physician's Office ☐ Retail Pharmacy
☐ Specialty Pharmacy ☐ Mail Order
☐ Other: __________
Name: __________
Phone: __________ Fax: __________
Address: __________
TIN: __________ PIN: __________

E. PRODUCT INFORMATION

Request is for: ☐ Berinert ☐ Cinryze ☐ Haegarda ☐ Firazyr ☐ Kalbitor ☐ Ruconest
Dose: ______________ **Frequency:** ______________

F. DIAGNOSIS INFORMATION – Please indicate primary ICD Code and specify any other where applicable.

Primary ICD Code: __________ Secondary ICD Code: __________ Other ICD Code: __________

G. CLINICAL INFORMATION – Required clinical information must be completed in its entirety for all precertification requests.

For All Requests – Please submit a copy of the Laboratory reports and clinicals with request

What is the patient's C4 level and date drawn? ______ Date: ____/____/____
What is the patient's C1-INH antigenic level and date drawn? ______ Date: ____/____/____
What is the patient's C1-INH functional level and date drawn? ______ Date: ____/____/____

☐ Yes ☐ No Have medications known to cause angioedema been evaluated and discontinued when appropriate?
☐ N/A (not on any medications known to cause angioedema)
If yes, please select which type of medication(s) have been discontinued:
☐ Ace inhibitors
☐ Estrogens
☐ Angiotensin II receptor blockers
☐ Other: Please explain: ______________

☐ Yes ☐ No Is the patient experiencing at least one symptom of moderate to severe attack?
If yes, please select the following symptom(s) the patient has experienced**:**
☐ Airway swelling
☐ Severe abdominal pain
☐ Facial swelling
☐ Nausea and vomiting
☐ Painful facial distortion
☐ Other: Please explain: ______________

Continued on next page

Hereditary Angioedema Injectable Medication Precertification Request

(All fields must be completed and legible for Precertification Review.)

Aetna Precertification Notification
503 Sunport Lane, Orlando, FL 32809
Phone: 1-866-503-0857
FAX: 1-888-267-3277

For Medicare Advantage Part B:
FAX: 1-844-268-7263

Patient First Name	Patient Last Name	Patient Phone	Patient DOB

G. CLINICAL INFORMATION ***(continued)*** – Required clinical information must be completed in its entirety for all precertification requests.

For Berinert, Firazyr, Kalbitor, or Ruconest requests for C4 level that is below the limits: (Type I & II)

☐ Yes ☐ No Will the medication be used for treatment of acute attacks associated with HAE?
☐ Yes ☐ No Does the patient have a low C1-INH antigenic or functional level?
If yes, please indicate which of the following pertains to the patient:
☐ low C1INH antigenic level
☐ low C1-INH functional level
☐ Yes ☐ No Will the requested medication be used in combination with Firazyr, Kalbitor, Ruconest, or Berinert?

For Berinert, Firazyr, Kalbitor, or Ruconest requests for C4 level that is normal or near normal limits: (Type III):

☐ Yes ☐ No Does the patient have clinical evidence of acute attacks associated with hereditary angioedema with a normal C1-INH function?
☐ Yes ☐ No Does the patient have a documented history of recurrent angioedema in the absence of concomitant hives or concomitant use of a medication known to cause angioedema?
☐ Yes ☐ No Is there documentation of a F12 mutation that is associated with the disease?
☐ Yes ☐ No Is there a positive family history of angioedema?
☐ Yes ☐ No Does the patient have documented evidence that treatment with chronic high-dose antihistamine therapy (e.g., cetirizine 40 mg/ day or equivalent) was ineffective?
If yes, please indicate the antihistamine and dosage that the patient has tried:
☐ Cetirizine ☐ Levocetirizine ☐ Xyzal ☐ Zyrtec ☐ Other: ____________________ Dose: ______________________
Please indicate trial dates: _____/_____/______ to _____/_____/______
☐ Yes ☐ No Was there an interval expected to be associated with 3 or more attacks of angioedema during treatment with the antihistamine?
☐ Yes ☐ No Will the requested medication be used in combination with Firazyr, Kalbitor, Ruconest, or Berinert?

For Ruconest

☐ Yes ☐ No Is Ruconest being requested for the treatment of laryngeal attacks?

For Firazyr

☐ Yes ☐ No Will Firazyr be used for treatment of acute attacks of angioedema induced from angiotensin converting enzyme (ACE) inhibitor?

For Cinryze

☐ Yes ☐ No Was treatment with Haegarda ineffective, not tolerated or contraindicated? ☐ Ineffective ☐ Not tolerated ☐ Contraindicated

For Cinryze & Haegarda

Please indicate the number of HAE attacks per month the patient is experiencing: _____
☐ Yes ☐ No Will it be used as prophylaxis against hereditary angioedema attacks?
☐ Yes ☐ No Is the patient **currently** experiencing any signs of acute angioedema?
☐ Yes ☐ No Does the patient have a documented HAE-causing mutation?
☐ Yes ☐ No Does the patient have a low C1-INH antigenic or functional level?
If yes, please indicate which of the following pertains to the patient:
☐ low C1INH antigenic level
☐ low C1-INH functional level
☐ Yes ☐ No Has the patient had an ineffective response to 17 alpha-alkylated androgens (e.g. danazol, stanozolol) for HAE prophylaxis?
If yes, please provide the name(s) and dates of medications tried:
________________________ Dates: _____/_____/______ to _____/_____/______
________________________ Dates: _____/_____/______ to _____/_____/______
________________________ Dates: _____/_____/______ to _____/_____/______
☐ Yes ☐ No Does the patient have an intolerance or contraindication to 17 alpha-alkylated androgens?
If yes, please select: ☐ Intolerance ☐ Contraindication
☐ Yes ☐ No Has the patient had an ineffective response to anti-fibrinolytic agents (e.g. epsilon aminocaproic acid, tranexamic acid) for HAE prophylaxis?
If yes, please provide the name(s) and dates the medication was tried**:**
________________________ Dates: _____/_____/______ to _____/_____/______
________________________ Dates: _____/_____/______ to _____/_____/______
________________________ Dates: _____/_____/______ to _____/_____/______
☐ Yes ☐ No Does the patient have an intolerance or contraindication to anti-fibrinolytic agents?
If yes, please select: ☐ Intolerance ☐ Contraindication
☐ Yes ☐ No Does the patient have a contraindication to 17 alpha-alkylated androgens **and** anti-fibrinolytic agents?
☐ Yes ☐ No Will Cinryze and Haegarda be used concomitantly?

H. ACKNOWLEDGEMENT

Request Completed By ***(Signature Required):*** ____ **Date:** _____/_____/______

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

The plan may request additional information or clarification, if needed, to evaluate requests.