



# Kalbitor® (ecallantide) Medication Precertification Request

Page 1 of 1

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

**Aetna Precertification Notification**  
503 Sunport Lane, Orlando, FL 32809

Phone: 1-866-752-7021

FAX: 1-888-267-3277

**For Medicare Advantage Part B:**

Phone: 1-866-503-0857

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 #:	Does patient have other coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No
Group #:	If yes, provide ID#: _____ Carrier Name: _____
Insured:	Insured: _____
Medicare: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide ID #: _____ Medicaid: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide ID #: _____	

## C. PRESCRIBER INFORMATION

First Name:		Last Name:			(Check One): <input type="checkbox"/> M.D. <input type="checkbox"/> D.O. <input type="checkbox"/> N.P. <input type="checkbox"/> P.A.	
Address:		City:	State:	ZIP:		
Phone:	Fax:	St Lic #:	NPI #:	DEA #:	UPIN:	
Provider Email:		Office Contact Name:			Phone:	
Specialty (Check one): <input type="checkbox"/> Allergist <input type="checkbox"/> Immunologist <input type="checkbox"/> Other: _____						

## D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

<b>Place of Administration:</b>		<b>Dispensing Provider/Pharmacy: (Patient selected choice)</b>	
<input type="checkbox"/> Self-administered	<input type="checkbox"/> Physician's Office	<input type="checkbox"/> Physician's Office	<input type="checkbox"/> Retail Pharmacy
<input type="checkbox"/> Outpatient Infusion Center	Phone: _____	<input type="checkbox"/> Specialty Pharmacy	<input type="checkbox"/> Other: _____
Center Name: _____		Name: _____	
<input type="checkbox"/> Home Infusion Center	Phone: _____	Address: _____	
Agency Name: _____		Phone: _____	Fax: _____
<input type="checkbox"/> Administration code(s) (CPT): _____		TIN: _____	PIN: _____
Address: _____			

## E. PRODUCT INFORMATION

**Request is for: Kalbitor (ecallantide) 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 (clinical documentation required for all requests):

**Please indicate the diagnosis:**

Hereditary angioedema (HAE) with C1 inhibitor deficiency or dysfunction confirmed by laboratory testing:  
Please indicate which of the following conditions does the patient have:  
 A C1 inhibitor (C1-INH) antigenic level below the lower limit of normal as defined by the laboratory performing the test  
 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)

HAE with normal C1 inhibitor confirmed by laboratory testing:  
Please indicate which of the following conditions does the patient have:  
 F12, angiotensinogen 1, or plasminogen gene mutation as confirmed by genetic testing  
 Family history of angioedema and angioedema refractory to a trial of high-dose antihistamine (e.g. cetirizine) for at least one month

Yes  No Will the medication be used for treatment of acute attacks associated with HAE?  
 Yes  No Will the requested medication be used in combination with Berinert, Firazyr or Ruconest?

### For Continuation of Therapy Requests:

Yes  No Has the patient experienced reduction in frequency, severity, and/or duration of attacks since starting treatment?

## 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.