Berinert® (C1 esterase inhibitor, human) Medication Precertification Request

(All fields must be completed and legible for precertification review.)

Aetna Precertification Notification
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? ☐ Yes ☐ No
Group #: _____ If yes, provide ID#: _____ Carrier Name: _____
Insured: _____ 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 ☐ Other: _____
Name: _____
Address: _____
Phone: _____ FAX: _____
TIN: _____ PIN: _____

E. PRODUCT INFORMATION

Request is for: Berinert (C1 esterase inhibitor, human) 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):

☐ Yes ☐ No Does the patient have a diagnosis of hereditary angioedema (HAE)?

Please indicate which clinical setting the requested medication will be used:

For Acute hereditary angioedema (HAE) attacks:

☐ Yes ☐ No Will the requested drug be used in combination with any other medication used for treatment of acute HAE attacks (e.g., Firazyr, Kalbitor Ruconest)?

☐ Yes ☐ No Has the patient had an ineffective response, contraindication or intolerance to Ruconest?

Which of the following applies to the patient?

☐ **Hereditary angioedema (HAE) with C1 inhibitor deficiency or dysfunction confirmed by laboratory testing**

☐ Yes ☐ No ☐ Unknown Does the patient have a C4 level below the lower limit of normal as defined by the laboratory performing the test prior to initiating therapy (i.e., testing at the time of diagnosis and/or prior to starting any biologic treatment)?

Please indicate which of the following conditions the patient has (i.e., condition/testing result at the time of diagnosis and/or prior to starting any biologic treatment):

☐ 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)

☐ Other

☐ **HAE with normal C1 inhibitor confirmed by laboratory testing**

Please indicate which of the following conditions the patient has:

☐ F12, angiopoietin-1, plasminogen, kininogen-1 (KNG1), heparan sulfate-glucosamine 3-0 sulfotransferase 6 (HS3ST6) or myoferlin (MYOF) gene mutation as confirmed by genetic testing

☐ **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

☐ Other

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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 Short-term preprocedural prophylaxis (i.e., prior to surgical or major dental procedures):

Which of the following applies to the patient?

☐ **Hereditary angioedema (HAE) with C1 inhibitor deficiency or dysfunction confirmed by laboratory testing**

☐ Yes ☐ No ☐ Unknown Does the patient have a C4 level below the lower limit of normal as defined by the laboratory performing the test prior to initiating therapy (i.e., testing at the time of diagnosis and/or prior to starting any biologic treatment)?

Please indicate which of the following conditions the patient has (i.e., condition/testing result at the time of diagnosis and/or prior to starting any biologic treatment):

☐ 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)

☐ Other

☐ **HAE with normal C1 inhibitor confirmed by laboratory testing**

Please indicate which of the following conditions the patient has:

☐ F12, angiopoietin-1, plasminogen, kininogen-1 (KNG1), heparan sulfate-glucosamine 3-0 sulfotransferase 6 (HS3ST6) or myoferlin (MYOF) gene mutation as confirmed by genetic testing

☐ **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

☐ Other

For Continuation of Therapy Requests (clinical documentation required):

Acute hereditary angioedema (HAE) attacks:

☐ Yes ☐ No Is the patient currently receiving the requested drug through samples or a manufacturer's patient assistance program?

☐ Yes ☐ No Has the patient experienced a reduction in severity and/or duration of attacks when the requested medication is used to treat an acute attack?

☐ Yes ☐ No Does the patient's attack frequency, attack severity, comorbid conditions and member's quality of life warrant prophylactic therapy?

→ ☐ Yes ☐ No Has prophylactic treatment been considered?

→ Please provide a brief rationale as to why prophylactic treatment has not been considered: _____

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.