



**Ruconest® (C1 esterase inhibitor, recombinant) Medication  
Precertification Request**

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

**Request is for: Ruconest (C1 esterase inhibitor, recombinant) 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):**

Yes  No Is the requested medication being used for the treatment of acute HAE attacks?

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

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-O 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

Continued on next page



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Patient First Name	Patient Last Name	Patient Phone	Patient DOB
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**G. CLINICAL INFORMATION** – Required clinical information must be completed in its entirety for all precertification requests.

**For Continuation of Therapy Requests (clinical documentation required for all requests):**

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.