



# Berinert® (C1 esterase inhibitor, human) 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:
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> <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: 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 Does the patient have a C4 level below the lower limit of normal as defined by the laboratory performing the test?  
 Please indicate which of the following conditions the patient has:  
 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, angiotensin-converting enzyme 2, plasminogen, kininogen-1 (KNG1), heparan sulfate-glucosaminyl 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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FAX: 1-844-268-7263

Patient First Name	Patient Last Name	Patient Phone	Patient DOB
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**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 Does the patient have a C4 level below the lower limit of normal as defined by the laboratory performing the test?

Please indicate which of the following conditions the patient has:

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, angiotensin-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.