Cigna®

Fax completed form to: (855) 840-1678
If this is an URGENT request, please call (800) 882-4462
(800.88.CIGNA)

Berinert, Cinryze, Firazyr, Kalbitor, Ruconest

PHYSICIAN INFORMATION			PATIENT INFORMATION		
* Physician Name:			*Due to privacy regulations we will not be able to respond via fax with the outcome of our review unless all asterisked (*) items on this form are completed.*		
Specialty:	* DEA, NPI or TIN:				
Office Contact Person:			* Patient Name:		
Office Phone:			* Cigna ID:	* Date of Birth:	
Office Fax:			* Patient Street Address:		
Office Street Address:			City:	State:	Zip:
City:	State:	Zip:	Patient Phone:		

Urgency:
☐ Standard ☐ Urgent (In checking this box, I attest to the fact that applying the standard review time frame may seriously jeopardize the customer's life, health, or ability to regain maximum function)

Medication requested:
☐ Berinert 500 unit kit
☐ Cinryze 500 unit vial
☐ Firazyr 30mg/3ml syringe
☐ Icatibant 30mg/30ml syringe
☐ Kalbitor 30mg/3ml vial
☐ Ruconest 2100 unit vial

Directions for use: Quantity: Duration of therapy: J-Code:

(for Berinert or Ruconest) What is your patient's current weight (kg)? ICD10:

Is this a new start or continuation of therapy? If your patient has already begun treatment with drug samples, please choose "new start of therapy". ☐ new start of therapy ☐ continued established therapy- start date:

(if continued therapy) Has your patient had a beneficial clinical response to therapy with this drug - as demonstrated by ANY of the following (A, B, C, D): A. Decrease in Hereditary Angioedema (HAE) attack severity; B. Decrease in duration of HAE attacks; C. Quick onset of symptom relief; D. Complete resolution of symptoms? ☐ Yes ☐ No
Please provide supportive documentation.

(if no) Please provide clinical support for continued use of this drug.

(if continued therapy and requesting Kalbitor) Has your patient had a good response to therapy with this drug as demonstrated by ANY of the following (i, ii, iii, or iv): i. Decrease in Hereditary Angioedema (HAE) attack severity; ii. Decrease in duration of HAE attacks; iii. Quick onset of symptom relief; iv. Complete resolution of symptoms? ☐ Yes ☐ No

Where will this medication be obtained?
☐ Accredo Specialty Pharmacy**
☐ Hospital Outpatient
☐ Retail pharmacy
☐ Other (please specify):
☐ Home Health / Home Infusion vendor
☐ Physician's office stock (billing on a medical claim form)
***Cigna's nationally preferred specialty pharmacy*

***Medication orders can be placed with Accredo via E-prescribe - Accredo (1620 Century Center Pkwy, Memphis, TN 38134-8822 | NCPDP 4436920), Fax 888.302.1028, or Verbal 866.759.1557*

Facility and/or doctor dispensing and administering medication:
Facility Name: State: Tax ID#:
Address (City, State, Zip Code):

Where will this drug be administered?

☐ Patient's Home ☐ Physician's Office
☐ Hospital Outpatient ☐ Other (please specify):

NOTE: *Per some Cigna plans, infusion of medication MUST occur in the least intensive, medically appropriate setting.*
Is this patient a candidate for re-direction to an alternate setting (such as alternate infusion site, physician's office, home) with assistance of a Specialty Care Options Case Manager? ☐ Yes ☐ No (provide medical necessity rationale):

Is the requested medication for a chronic or long-term condition for which the prescription medication may be necessary for the life of the patient? ☐ Yes ☐ No

Diagnosis related to use:

☐ hereditary angioedema (HAE) ☐ other (please specify):

Clinical Information:

****This drug requires supportive documentation (chart notes, lab and test results, etc). Supportive documentation for all answers must be attached with this request****

For all products:

****Supportive documentation for all answers must be attached with this request.****

Does your patient have a confirmed pathogenic variant in the SERPING1, F12, ANGPT1, PLG OR KNG1 gene? ☐ Yes ☐ No **documentation required

(if no) Did your patient have a C4 level below the lower limit of normal as defined by the laboratory performing the test at baseline?? ☐ Yes ☐ No **documentation required

Does/Did your patient have low levels of functional C1-INH protein (less than 50% of normal) at baseline, as documented by laboratory reference values? ☐ Yes ☐ No
**documentation required

(if no) Does/Did your patient have low C1-INH antigenic levels (less than 50% of normal) at baseline, as documented by laboratory reference values? ☐ Yes ☐ No
**documentation required

(if continuation) Does the requested medication continue to be prescribed by, or in consultation with, an allergist/immunologist? ☐ Yes ☐ No

(if new start) Is the requested medication being prescribed by, or in consultation with, an allergist/immunologist? ☐ Yes ☐ No

For Berinert Cinryze:

What is the patient's diagnosis?

☐ Hereditary Angioedema (HAE) – Prophylaxis
☐ Hereditary Angioedema (HAE) – Treatment of Acute Attacks
☐ other

(if other) What is the diagnosis related to use?

(if continued & treatment) Is your patient having a beneficial response to therapy with this medication - as demonstrated by ANY of the following (i, ii, iii, or iv): i. Decrease in duration of HAE attacks; ii. Quick onset of symptom relief; iii. Complete resolution of symptoms; or iv. decrease in HAE acute attack frequency or severity? ☐ Yes ☐ No

(if no) Please provide support for continued use.

(if HAE treatment) While receiving the requested medication (Berinert or Cinryze), will your patient also be treated with any other FDA-approved treatments for acute Hereditary Angioedema (HAE) attacks (for example, Berinert, Cinryze, Firazyr, icatibant, Kalbitor, Ruconest, or Sajazir)? ☐ Yes ☐ No

(if continued & prophylaxis) Is your patient having a beneficial response to therapy with this medication - as demonstrated by ANY of the following (i, ii, or iii): i. decrease in Hereditary Angioedema (HAE) acute attack frequency; ii. decrease in HAE attack severity; iii. decrease in duration of HAE attacks? ☐ Yes ☐ No

(if no) Please provide support for continued use.

(if HAE prophylaxis) While receiving the requested medication (Berinert or Cinryze), will your patient also be treated with any other FDA-approved prophylactic treatments for Hereditary Angioedema (HAE) (for example, Berinert, Cinryze, Haegarda, Takhzyro, or

Orladeyo)? ☐ Yes ☐ No

The covered alternative is icatibant (Sajazir). If your patient has tried this drug, please provide drug strength, date(s) taken and for how long, and what the documented results were of taking this drug, including any intolerances or adverse reactions your patient experienced. If your patient has NOT tried this drug, please provide details why your patient can't try this alternative.

Per the information provided above, which of the following is true for your patient in regard to the covered alternative?
☐ The patient tried the alternative, but it didn't work.
☐ The patient tried the alternative, but they did not tolerate it.
☐ The patient cannot try the alternative because of a contraindication to this drug.
☐ Other

For Firazyr and Icatibant:

****Supportive documentation for all answers must be attached with this request.****

Is this drug being used for the treatment of acute angioedema attacks with Hereditary Angioedema (HAE)? ☐ Yes ☐ No

Does your patient have a history of a moderate or severe attacks (for example: airway swelling, severe abdominal pain, facial swelling, nausea and vomiting, painful facial distortion)? ☐ Yes ☐ No

While receiving the requested drug, will your patient also be treated with any of the following? (check all that apply)
☐ Berinert
☐ Kalbitor
☐ Ruconest
☐ Sajazir
☐ other (please specify):

For Firazyr only- Has your patient tried a generic formulation of icatibant? ☐ Yes ☐ No

(if yes) Did your patient have a documented intolerance to icatibant? ☐ Yes ☐ No

For Ruconest:

****Supportive documentation for all answers must be attached with this request.****

What is the patient's diagnosis?

☐ Hereditary Angioedema (HAE) – Prophylaxis
☐ Hereditary Angioedema (HAE) – Treatment of Acute Attacks
☐ other
(if other) What is the diagnosis related to use?

(if continuation and for treatment) Is your patient having a beneficial response since initiating Ruconest therapy (for example, decrease in the duration of HAE attacks, quick onset of symptom relief, complete resolution of symptoms, or decrease in HAE acute attack frequency or severity)? ☐ Yes ☐ No

(if HAE treatment) While receiving the requested drug, will your patient also be treated with any other FDA-approved prophylactic treatments for HAE (for example, Berinert, Cinryze, Firazyr, icatibant, Kalbitor, or Sajazir)? ☐ Yes ☐ No

The covered alternative is icatibant (Sajazir). If your patient has tried this drug, please provide drug strength, date(s) taken and for how long, and what the documented results were of taking this drug, including any intolerances or adverse reactions your patient experienced. If your patient has NOT tried this drug, please provide details why your patient can't try this alternative.

Per the information provided above, which of the following is true for your patient in regard to the covered alternative?
☐ The patient tried the alternative, but it didn't work.
☐ The patient tried the alternative, but they did not tolerate it.
☐ The patient cannot try the alternative because of a contraindication to this drug.
☐ Other

For Kalbitor:
****Supportive documentation for all answers must be attached with this request.****

Is this drug being used for the treatment of acute angioedema attacks with Hereditary Angioedema (HAE)? ☐ Yes ☐ No

The covered alternative is icatibant (for example, Sajazir). If your patient has tried this drug, please provide drug strength, date(s) taken and for how long, and what the documented results were of taking this drug, including any intolerances or adverse reactions your patient experienced. If your patient has NOT tried this drug, please provide details why your patient can't try this alternative.

_____

Per the information provided above, which of the following is true for your patient in regard to the covered alternative?
☐ The patient tried the alternative, but it didn't work.
☐ The patient is able to try the alternative, but has not done so yet.
☐ The patient tried the alternative, but had a significant intolerance to it.
☐ The patient can't try the alternative because of one of the following: contraindication according to the FDA label; a warning per the prescribing information (labeling); a disease characteristic or clinical factor the patient has.
☐ Other

(if other) Please specify reason. _____

While receiving the requested drug, will your patient also be treated with any of the following? (check all that apply)
☐ Berinert
☐ Kalbitor
☐ icatibant
☐ Firazyr
☐ Ruconest
☐ Sajazir
☐ other (please specify):

Additional pertinent information: *(include alternatives tried, date(s) taken and for how long, and what the documented results were of taking this drug, including any intolerances or adverse reactions your patient experienced):*

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan or insurer its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature:_____ **Date:**_____

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