Angioedema Step Therapy

Berinert J0597/ Cinryze J0598/ Ruconest J0596 (C-1 esterase inhibitor, human), Kalbitor (ecallantide) J1290 are non-preferred. The preferred product is: Firazyr (icatibant acetate) J1744

Prior Authorization Step Therapy Request

Medicare Part B Form

*Instructions: * Indicates required information – Form may be returned if required information is not provided. Please fax this request to the appropriate fax number listed at the bottom of the page.*

☐	Date Requested _____
	Requestor _____ Clinic name: _____ Phone / Fax

MEMBER INFORMATION

*Name:_____ *ID#:_____ *DOB:_____

PRESCRIBER INFORMATION

*Name:_____ ☐MD ☐FNP ☐DO ☐NP ☐PA *Phone:_____

*Address:_____ *Fax:_____

DISPENSING PROVIDER / ADMINISTRATION INFORMATION

*Name:_____ Phone:_____

*Address:_____ Fax:_____

PROCEDURE / PRODUCT INFORMATION

HCPC Code	Name of Drug ☐ Self-administered	Dose (Wt: _____ kg Ht:_____)	Frequency	End Date if known

☐Chart notes attached. **Other important information:**_____

Diagnosis: ICD10: _____ **Description**: _____

☐ Provider attests the diagnosis provided is an FDA-Approved indication for this drug

CLINICAL INFORMATION

☐ New Start or Initial Request: (Clinical documentation required for all requests)

☐ **Provider has reviewed the attached "Criteria for Approval" and attests the member meets ALL required PA criteria.**

If not, please provide **clinical rationale** for formulary exception: _____

_____

☐ Continuation Requests: (Clinical documentation required for all requests)

☐ **Provider has reviewed the attached "Criteria for Continuation" and attests the member meets ALL required PA Continuation criteria.**

☐ Patient had an adequate response or significant improvement while on this medication.

If not, please provide clinical rationale for continuing this medication: _____

_____

ACKNOWLEDGEMENT

Request 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.

THIS AUTHORIZATION IS NOT A GUARANTEE OF PAYMENT. PAYMENT IS BASED ON BENEFITS IN EFFECT AT THE TIME OF SERVICE, MEMBER ELIGIBILITY AND MEDICAL NECESSITY.

For questions or assistance, please contact Customer Service at 1-877-672-8620, daily, 8am – 8pm (PST) (TTY users should call 1-800-735-2900).

Prior Authorization Group – Angioedema Drugs PA

Drug Name(s):

BERINERT	**RUCONEST**
CINRYZE	**C1 ESTERASE INHIBITOR**
KALBITOR	**ECALLANTIDE**
FIRAZYR	**ICATIBANT ACETATE**

Criteria for approval of Prior Authorization Drug:

1. Prescribed for an approved FDA diagnosis (as listed below):
2. Member has tried and failed at least ONE of the formulary alternatives: **Firazyr** OR
   - There is clinical documentation stating formulary alternatives are contraindicated.
3. Drug is being used appropriately per MCG GUIDELINES, CMS recognized compendia, authoritative medical literature, evidence-based guidelines and/or accepted standards of medical practice.
4. Member does not have any clinically relevant contraindications, or CMS/Plan exclusions, to the requested drug.

- If the member meets all these criteria, they may be approved by the Plan for the requested drug.
- Quantity limits and Tiering will be determined by the Plan.

Exclusion Criteria:

N/A

Prescriber Restrictions:

N/A

Coverage Duration:

Approvals will be for 6 months

FDA Indications:

Berinert, Cinryze

- Hereditary angioedema, abdominal, facial, or laryngeal attacks
- Hereditary angioedema; prophylaxis

Ruconest, Kalbitor

- Hereditary angioedema, acute attacks

Off-Label Uses:

Berinert, Cinryze

- Acute ST segment elevation myocardial infarction – emergency CABG

Step Therapy Drug(s) and FDA Indications:

Firazyr

- Hereditary angioedema, acute attacks

Age Restrictions:

Kalbitor: 12 years and older

Other Clinical Considerations:

N/A

Resources:

https://www.micromedexsolutions.com/micromedex2/librarian/CS/25039B/ND_PR/evidencexpert/ND_P/evidencexpert/DUPLICATIONSHIELDSYNC/A3C728/ND_PG/evidencexpert/ND_B/evidencexpert/ND_AppProduct/evidencexpert/ND_T/evidencexpert/PFActionId/evidencexpert.DoIntegratedSearch?SearchTerm=C1%20Esterase%20Inhibitor%2C%20Human&UserSearchTerm=C1%20Esterase%20Inhibitor%2C%20Human&SearchFilter=filterNone&navitem=searchGlobal#

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