Pharmacy Prior Authorization Form

Fax completed form to: 877.974.4411 toll free, or 616.942.8206

This form applies to: ☒ **Commercial** ☒ **Commercial Individual (PPACA)** ☐ **Medicaid**

This request is: ☐ **Urgent** (life threatening) ☐ **Non-Urgent** (standard review)

Urgent means the standard review time may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.

Berinert® (C1 Esterase Inhibitor, Plasma-derived concentrate)

Reset Form

Member

Last Name: _____ First Name: _____

ID #: _____ DOB: _____ Gender: _____

Primary Care Physician: _____

Requesting Provider: _____ Prov. Phone: _____ Prov. Fax: _____

Provider Address: _____

Provider NPI: _____ Contact Name: _____

Date: _____

Product Information

☐ New request ☐ Continuation request

Drug product: ☐ Berinert 500 unit vial

Start date (or date of next dose): _____

Date of last dose (if applicable): _____

Dosing frequency: _____

Drug cost information

The wholesale acquisition cost for one vial is $2,815. The annual cost of treatment with this drug will vary depending on the patient's circumstances. The average cost of one treatment is $11,260.

Precertification Requirements

Before this drug is covered, the patient must meet all of the following requirements:

1. Diagnosis of hereditary angioedema (HAE) type I or type II
    a. Requires submission of two sets of C4, C1-INH protein, and C1-INH function lab results confirming diagnosis
2. Greater than 12 years of age
3. Patient has received training for self-administration
4. Patient has attacks:
    a. Affecting upper airways, OR
    b. Involving the face, neck, or abdomen, OR
    c. Resulting in debilitation or dysfunction
5. Berinert is being used only for the treatment of acute attacks
6. Patient has tried Firazyr with documentation to support it being ineffective in controlling acute attacks
7. Berinert is limited to one fill of 20 units/kg (supplied in 500 unit vials). Each additional fill requires documentation of the patient's use of the previous supply of Berinert

NOTE: Priority Health may require you get a second opinion confirming your diagnosis prior to covering this medication.

All fields must be complete and legible for review. Your office will receive a response via fax.

Updated 12/2017
Last reviewed 01/2018

Note: Authorization for indications not approved by the Food and Drug Administration (FDA) or recognized in CMS-accepted compendia (e.g. DrugDex, AHFS, U.S. Pharmacopeia, and also Clinical Pharmacology for oncology indications only) require supporting evidence for coverage. Please provide two published peer-reviewed literature articles supporting the drug's use for the identified indication.

New request
Priority Health Precertification Documentation

A. What condition is this drug being requested for?

☐ Hereditary angioedema type I or II (two sets of C4, C1-INH protein, and C1-INH function lab results must be submitted to Priority Health)

☐ *Other – the patient's condition is:* _____

Rationale for use: _____

B. Has the patient received self-administration training?

☐ Yes
☐ No

C. Will the patient being using Berinert for acute or prophylactic treatment?

☐ Acute
☐ Prophylactic

D. Has the patient had a trial of Firazyr for acute attacks?

☐ Yes
☐ No

Rationale for use: _____

E. What is the patient's current weight? _____

Request to continue a previously authorized approval
Priority Health Precertification Documentation

A. What was the date of use for the supply of Berinert dispensed? (Please provide accompanying documentation)_____
_____
_____

Additional information

Note: The recommended dose of Berinert is 20 units/kg infused at 4 ml/min. Berinert is not covered in combination with Firazyr, Ruconest, or Kalbitor.

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Updated 12/2017
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