PriorityHealth

Medical Prior Authorization Form

Fax completed form to: 877.974.4411 toll free, or 616.942.8206

This form applies to: ☒ **Commercial (Traditional)** ☒ **Commercial (Individual/Optimized)**
☐ **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.

Cinryze® (Plasma-derived C1INH)

Member

Last Name: _____ First Name: _____

ID #: _____ DOB: _____ Gender: _____

Primary Care Physician: _____

Requesting Physician: _____ Phys. Phone: _____ Phys. Fax: _____

Physician Address: _____

Physician NPI: _____ Contact Name: _____

Provider Signature: _____ Date: _____

Product Information

☐ New request ☐ Continuation request

Drug product: ☐ Cinryze 500 unit vial

Start date (or date of next dose): _____

Date of last dose (if applicable): _____

Dose:_____ **Dose Frequency**:_____

Place of administration:
☐ Physician's office
☐ Outpatient infusion
Facility: _____ NPI:_____ Fax:_____
☐ Home infusion
Facility: _____ NPI:_____ Fax:_____

Billing:
☐ Physician to buy and bill
☐ Facility to buy and bill
☐ Specialty Pharmacy
Pharmacy:_____ NPI:_____ Fax:_____

ICD-10 Diagnosis code(s): _____

Drug cost information

The wholesale acquisition cost for one dose (2 vials) is $5,517. The annual cost of treatment at the FDA labeled dosing is $573,828, but will vary depending on the patient's circumstances.

All fields must be complete and legible for review. Your office will receive a response via fax. No changes made since 09/2018

Last reviewed 09/2018

Precertification Requirements

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

1. Diagnosis of hereditary angioedema 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. Patient has received training for self-administration
3. Cinryze is being used only for prophylaxis of acute attacks
    a. Documentation that patient has acute attacks at least twice per month must be submitted to Priority Health
4. Patient has failed one previous optimized prophylactic treatment (e.g. danazol 600 mg total daily dose) and Haegarda

For continuation, patient must have met the following requirements:

1. Must be compliant on therapy
2. Must have documentation showing a decrease in the frequency of acute attacks from baseline (prior to treatment)

NOTE: Coverage of Cinryze is only provided under the Medical benefit. Additionally, Priority Health may require you get a second opinion confirming your diagnosis prior to covering this medication.

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.

Priority Health Precertification Documentation

A. What condition is this drug being requested for?

☐ Hereditary angioedema type I or II
☐ *Other – the patient's condition is:* _____
Rationale for use: _____

B. Have 2 sets of C4, C1-INH protein, and C1-INH function lab results been submitted to Priority Health?

☐ Yes
☐ No; *Rationale for use:* _____

C. Has the patient received self-administration training?

☐ Yes
☐ No

D. Will the patient being using Cinryze for acute or prophylactic treatment?

☐ Acute
☐ Prophylactic (documentation that the patient has acute attacks at least twice per month must be submitted to Priority Health)

E. Has the patient had a trial of at least one other prophylactic treatment?

☐ Yes

Drug	Dose	Dates	Outcome

☐ No
Rationale for use: _____

F. Has the patient had a trial of Haegarda?

☐ Yes
☐ No; *rationale for use* _____

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Last reviewed 09/2018

Renewal request
Priority Health Precertification Documentation

A. Has the patient been compliant on therapy?

☐ Yes
☐ No; *Rationale for use:* _____

B. Has there been a decrease in the frequency of acute attacks since starting Haegarda (documentation must be provided)?

☐ Yes
☐ No; *Rationale for use:* _____

Additional information

Note: The maximum covered dose of Cinryze is 1000 units infused at 1 ml/min every 3 to 4 days. When criteria are met, coverage will be approved for 12 months.

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Last reviewed 09/2018