Pharmacy 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.

Kalbitor® (ecallantide)

Member

Last Name: _____ First Name: _____

ID #: _____ DOB: _____ Gender: _____

Primary Care Physician: _____

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

Provider Address: _____

Provider NPI: _____ Contact Name: _____

Provider Signature: _____ Date: _____

Product Information

☐ New request ☐ Continuation request

Drug product: ☐ Kalbitor solution 10mg/mL

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 $4,418. The annual cost of treatment with this drug will vary depending on the patient's circumstances. The average cost of one treatment is $13,255.

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 is 12 years of age or older
3. Patient has attacks:
    a. Affecting upper airways, OR
    b. Involving the face, neck, or abdomen, OR
    c. Resulting in debilitation or dysfunction
4. Kalbitor is being used only for the treatment of acute attacks
5. Must be refractory to at least one optimized prophylactic treatment including an androgen and/or antifibrinolytic (e.g. danazol 600 mg total daily dose)
6. Patient has tried Firazyr with documentation to support it being ineffective in controlling acute attacks

- Kalbitor is limited to a total of six injections (two doses of 30mg SUBQ given as three 10mg injections) on hand. Each additional fill requires documentation of the patient's use of the previous supply of Kalbitor, as well as, documentation of symptom relief with the use of Kalbitor. For example, if the patient has one dose of 30 mg (three 10 mg syringes) on hand , then Priority Health will authorize one dose of 30 mg to provide a total on hand supply of two 30 mg doses as long as Kalbitor showed benefit for the patient.

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 09/2018
Last reviewed 09/2018

Note: Authorization for indications, dosing, or a route of administration 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 appropriateness of the drug, the dosing of the drug, or the route of administration to be used 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
- ☐ *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. Will the patient being using Kalbitor 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. Is the patient refractory to one optimized prophylactic treatment that includes an androgen and/or antifibrinolytic?

- ☐ Yes

Drug: _____ **Dose**: _____ **Dates of use**: _____

Drug: _____ **Dose**: _____ **Dates of use**: _____

- ☐ No; *Rationale for use:* _____

Request for Continuation
Priority Health Recertification Documentation

A. How many Kalbitor syringes does the patient have on hand? _____ syringes

B. Please list the dates of use for the supply of Kalbitor previously dispensed (and also provide accompanying documentation):

_____

_____

_____

C. Has documentation been submitted showing the patient has had symptom relief from the use of Kalbitor?

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

Additional information

Note: The recommended dose of Kalbitor is 30mg SUBQ in three 10mg (1 mL) injections; an additional dose of 30mg may be administered within a 24 hour period if attack persists. Kalbitor is not covered in combination with Firazyr, Ruconest, or Berinert.

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

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