Priority Health Medicare prior authorization form

Fax completed form to: 877.974.4411 toll free, or 616.942.8206

This form applies to: ☐ **Medicare Part B** ☒ **Medicare Part D**

This request is: ☐ **Expedited request** ☐ **Standard request**

Your request will be expedited if you haven't gotten the prescription and Priority Health Medicare determines, or your prescriber tells us, that your life or health may be at risk by waiting.

Ruconest® (recombinant c1 esterase inhibitor)

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: ☐ Ruconest 2,100 unit vial

Start date (or date of next dose): _____

Date of last dose (if applicable): _____

Dosing frequency: _____

Note: Ruconest does not require prior approval when administered in the emergency department or during an inpatient hospital stay.

Drug cost information

The wholesale acquisition cost for two Ruconest vials is $9,500. The annual cost of treatment with this drug will vary depending on the patient's circumstances.

Precertification Requirements

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

1. Diagnosis of hereditary angioedema
2. Age 13 or older

Medically accepted indication

This drug is only covered under Medicare Part D when it is used for a medically accepted indication. A medically accepted indication is a use of the drug that is *either*:

- approved by the Food and Drug Administration. (That is, the Food and Drug Administration has approved the drug for the diagnosis or condition for which it is being prescribed.)
- — *or* — supported by certain reference books. (These reference books are the American Hospital Formulary Service Drug Information and the DRUGDEX Information System.)

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

Updated 12/2017
Last reviewed 09/2018

Priority Health Precertification Documentation

A. What is the patient's diagnosis?

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

B. If the patient previously used Ruconest, when were the last three injections given? _____

_____

Priority Health Medicare exception request

Do you believe one or more of the prior authorization requirements should be waived? ☐ Yes ☐ No
If yes, you must provide a statement explaining the medical reason why the exception should be approved.

Would Ruconest likely be the most effective option for this patient?

☐ No
☐ Yes, because: _____

_____

_____

If the patient is currently using Ruconest, would changing the patient's current regimen likely result in adverse effects for the patient?

☐ No
☐ Yes, because: _____

_____

_____

Additional information

When authorized, Priority Health will cover up to one fill of four vials for each acute attack. Each additional fill requires documentation of the patient's use of the previous supply of Ruconest and only the number of vials used will be replaced. Reauthorization required every 6 months.

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