Fax completed form to: (855) 840-1678
If this is an URGENT request, please call (800) 882-4462
(800.88.CIGNA)

Berinert, Cinryze, Haegarda, Kalbitor, Firazyr, Ruconest, Takhzyro

PHYSICIAN INFORMATION			PATIENT INFORMATION		
* Physician Name:			*Due to privacy regulations we will not be able to respond via fax with the outcome of our review unless all asterisked (*) items on this form are completed.*		
Specialty:	* DEA, NPI or TIN:				
Office Contact Person:			* Patient Name:		
Office Phone:			* Cigna ID:	* Date of Birth:	
Office Fax:			* Patient Street Address:		
Office Street Address:			City:	State:	Zip:
City:	State:	Zip:	Patient Phone:		

Urgency:
☐ Standard ☐ Urgent (In checking this box, I attest to the fact that applying the standard review time frame may seriously jeopardize the customer's life, health, or ability to regain maximum function)

Medication requested:
☐ Berinert 500 unit kit
☐ Cinryze 500 unit vial
☐ Firazyr 30mg/3ml syringe
☐ Haegarda 2000 unit vial ☐ Haegarda 3000 unit vial
☐ Icatibant 30mg/30ml syringe
☐ Kalbitor 30mg/3ml vial
☐ Ruconest 2100 unit vial
☐ Takhzyro 300/2ml vial

Directions for use: Quantity: Duration of therapy: J-Code:

(for Berinert, Haegarda or Ruconest) What is your patient's current weight (kg)? ICD10:

Is this a new start or continuation of therapy? If your patient has already begun treatment with drug samples, please choose "new start of therapy". ☐ new start of therapy ☐ continued established therapy- start date:

(if continued therapy) Has your patient had a good response to therapy with this drug (for example, decrease in frequency of HAE acute attacks, decrease in HAE attack severity, decrease in duration of HAE attacks)? ☐ Yes ☐ No
Please provide clinical support.

(if continued therapy and requesting Takhzyro at 300mg every 2 weeks dosing) Has there been an attempt to taper the dosing to 300mg every 4 weeks? ☐ Yes ☐ No
(if no) Please explain:

Where will this medication be obtained?
☐ Accredo Specialty Pharmacy**
☐ Prescriber's office stock (billing on a medical claim form)
☐ Other (please specify):
☐ Retail pharmacy
☐ Home Health / Home Infusion vendor
***Cigna's nationally preferred specialty pharmacy*

*****Medication orders can be placed with Accredo via E-prescribe - Accredo (1640 Century Center Pkwy, Memphis, TN 38134-8822 | NCPDP 4436920), Fax 888.302.1028, or Verbal 866.759.1557*

Facility and/or doctor dispensing and administering medication:
Facility Name: State: Tax ID#:
Address (City, State, Zip Code):

Is the requested medication for a chronic or long-term condition for which the prescription medication may be necessary for the life of the patient? ☐ Yes ☐ No

Diagnosis related to use:
☐ hereditary angioedema (HAE) ☐ other (please specify):

Clinical Information:

****This drug requires supportive documentation (chart notes, lab and test results, etc). Supportive documentation for all answers must be attached with this request****

For all products:

****Supportive documentation for all answers must be attached with this request.****

Does your patient have a confirmed monoallelic mutation in either the SERPING1 or F12 gene which is known to cause HAE?
☐ Yes ☐ No ****documentation required**

(if no) Did your patient have a C4 level below the lower limit of normal as defined by the laboratory performing the test?
☐ Yes ☐ No ****documentation of labs required**

Did/does your patient have a C1 inhibitor (C1INH) antigenic level below the lower limit of normal as defined by the laboratory performing the test? ☐ Yes ☐ No ****documentation of labs required**

(if no) Did your patient have a C1INH functional level below the lower limit of normal as defined by the laboratory performing the test?
☐ Yes ☐ No ****documentation of labs required**

If your patient was/is taking any medications known to cause these attacks (for example: ACE-I, ARB, or estrogens), have these been evaluated and discontinued when appropriate? ☐ Yes or patient was not taking any known medications ☐ No

Is this drug being prescribed by, or in consultation with, an allergist/immunologist or a physician who specializes in the treatment of HAE or related disorders? ☐ Yes ☐ No

For Cinryze, Haegarda, Takhzyro:

****Supportive documentation for all answers must be attached with this request.****

Is this drug being used to prevent angioedema attacks? ☐ Yes ☐ No

Does your patient have a history of 2 or more moderate or severe attacks per month (for example airway swelling, severe abdominal pain, facial swelling, nausea and vomiting, painful facial distortion)? ☐ Yes ☐ No

While receiving the requested drug, will your patient also be treated with any of the following? (check all that apply)
☐ Cinryze ☐ Haegarda ☐ Takhzyro ☐ other (please specify):

For Berinert, Firazyr, Icatibant and Kalbitor:

****Supportive documentation for all answers must be attached with this request.****

Is this drug being used for the treatment of acute angioedema attacks? ☐ Yes ☐ No

Does your patient have a history of a moderate or severe attacks (for example: airway swelling, severe abdominal pain, facial swelling, nausea and vomiting, painful facial distortion)? ☐ Yes ☐ No

Is this request for a quantity to treat more than 2 attacks per month? ☐ Yes ☐ No

If yes- please provide clinical information to support:

While receiving the requested drug, will your patient also be treated with any of the following? (check all that apply)
☐ Berinert ☐ Firazyr ☐ Icatibant ☐ Kalbitor ☐ Ruconest ☐ other (please specify):

For Firazyr only- Has your patient tried a generic formulation of icatibant? ☐ Yes ☐ No

(if yes) Did your patient have a documented intolerance to icatibant? ☐ Yes ☐ No

For Ruconest:

****Supportive documentation for all answers must be attached with this request.****

Is this drug being used for treatment of acute angioedema attacks? ☐ Yes ☐ No

Does your patient have a history of moderate or severe attacks involving the abdomen, face, or extremities? ☐ Yes ☐ No

Is this request for a quantity to treat more than 2 attacks per month? ☐ Yes ☐ No

If yes- please provide clinical information to support:

While receiving the requested drug, will your patient also be treated with any of the following? (check all that apply)
☐ Berinert ☐ Firazyr ☐ Icatibant ☐ Kalbitor ☐ Ruconest ☐ other (please specify):

For Berinert, Kalbitor, Ruconest:

Does your patient have documented failure or inadequate response, contraindication per FDA label, intolerance or is not a candidate for one formulation of icatibant (generic Firazyr)? ☐ Yes ☐ No

Additional pertinent information: *(include alternatives tried, date(s) taken and for how long, and what the documented results were of taking this drug, including any intolerances or adverse reactions your patient experienced):*

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan or insurer its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature:_____ **Date:**_____

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Our standard response time for prescription drug coverage requests is 5 business days. If your request is urgent, it is important that you call us to expedite the request. View our Prescription Drug List and Coverage Policies online at cigna.com.

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