MedStar Medicare Choice

MedStar Medicare Choice
Pharmacy Services
Phone: 855-266-0712
Fax: 855-862-6517

# CINRYZE
## Prior Authorization Form

| | |
|---|---|
| □ Standard Request (72 hours)<br>□ Expedited Request (24 hours) | If you or your prescriber believe that waiting 72 hours for a standard decision could seriously harm your life, health, or ability to regain maximum function, you can request an expedited decision. For expedited requests you will receive a decision within 24 hours. You cannot request an expedited coverage determination if you are requesting reimbursement for a drug you already received. |

## Demographics

| Patient Information | | Prescriber Information | |
|---|---|---|---|
| Patient Name: | | Prescriber Name: | |
| DOB: | Age: | NPI#: | Specialty: |
| Health Plan ID#: | | Phone: | Fax: |
| Pharmacy Name: | Pharmacy Phone: | Office Contact: | Direct Phone # or Ext: |

## Medication Information

| Drug Requested: | Strength: | Directions: | Quantity Dispensed: | Day Supply: |
|---|---|---|---|---|
| Cinryze | 500units Powder Vial (IV) | | | |

| | | |
|---|---|---|
| □ New medication<br>□ Continuation of therapy | Start Date: | If this is continuation of therapy, please provide CHART DOCUMENTATION indicating the member showed improvement while on therapy. |

## Billing Information

| | | |
|---|---|---|
| □ Billed by **PHARMACY** dispensed to the member *or* provider for administration. | □ Billed under **MEDICAL** benefit by provider.<br>J CODE:_____<br>ICD-10 Code:_____ | Place of Administration:<br>□ Physician's Office<br>□ Hospital/Clinic<br>□ Patient Home |

## Clinical Information

| Diagnosis: | Date Diagnosed: |
|---|---|

Is Cinryze being used as prophylactic therapy for the prevention of Hereditary Angioedema (HAE) attacks? □ Yes □ No

Has the member had a trial/failure, intolerance, or contraindication to an attenuated androgen (e.g., danazol, stanozolol, oxandrolone)? □ Yes □ No
If Yes, Please list reason for discontinuation:_____

The member must have a diagnosis of HAE confirmed by the following lab values on **2 separate instances.**

- C4 complement level
- C1q complement level (not required for age under 18)
- C1 esterase inhibitor antigenic level
- C1 esterase inhibitor functional level

*A copy of lab report with reference ranges is required.*

Chart documentation included? □ Yes □ No
□ Documentation of each HAE attack is required (including number of attacks per month and attack severity).
□ A copy of lab report with reference ranges is required.

**Please provide any additional information which should be considered in the space below:**