PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Cinryze

Phone: 800-728-7947 Fax back to: 866-880-4532

The Scott & White Health Plan Pharmacy Department manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

Patient Name:	**Prescriber Name:** **Supervising Physician:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

Q1. What diagnosis is this drug being prescribed for?

☐ Hereditary angioedema (HAE) ☐ Other (please specify)

Q2. Please provide ICD code(s) for diagnosis.

Q3. Which type of request is this?

☐ Initial ☐ Continuation (please provide start date)

Q4. For INITIAL REQUEST, please provide clinical documentation of diagnosis, chart notes, labs, anticipated attack frequency, and any additional documentation that may be beneficial to pharmacist and medical director during the prior authorization case review.

Q5. For CONTINUATION, please supply clinical documentation of documented patient response and ability to tolerate medication.

Q6. Please select the prescriber's specialty.

☐ Allergist

PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Cinryze

Phone: 800-728-7947 **Fax back to: 866-880-4532**

The Scott & White Health Plan Pharmacy Department manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

Patient Name:	**Prescriber Name:** **Supervising Physician:**

☐ Immunology Specialist
☐ Hematologist
☐ Other (Please Specify)

Q7. Is the patient using this for PROPHYLAXIS of acute HAE attacks?

☐ Yes ☐ No (Please use form for HAE treatment drugs)

Q8. Does the patient have any of the following? Must be confirmed through chart notes.

☐ Two or more attacks per month requiring therapy
☐ Disabling symptoms 5 or more days per month
☐ Laryngeal edema
☐ Scheduled major dental work or surgical procedure requiring short term prophylaxis (please provide procedure period)

Q9. Does the patient have failure of an adequate trial of, clinically significant intolerance to, or contraindication to any of the following? If yes, please specify.

☐ Attenuated androgens (ex. danazol, stanozolol)
☐ Antifibrinolytics (ex. aminocaproic acid)
☐ Other (please specify)

Q10. Does the patient have a contraindication to therapy?

☐ Yes ☐ No

Q11. Is the patient using any medications know to cause angioedema (i.e. ACE inhibitor, ARB, or estrogen)?

☐ Yes (please explain) ☐ No

Q12. Will Cinryze be the only injectable medication used for prophylaxis of HAE attacks?

☐ Yes ☐ No

Q13. If request is for CONTINUATION, has the patient shown improvement with any of the following?

☐ Approaching 2 or fewer acute HAE attacks per month while on prophylaxis
☐ A decrease in quantity, severity, and length of HAE attacks
☐ Other (please specify)

Q14. Who is the ENTITY that will be submitting the CLAIM for the DRUG and seeking reimbursement?

Scott&White HEALTH PLAN
PART OF BAYLOR SCOTT & WHITE HEALTH

PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Cinryze

Phone: 800-728-7947 **Fax back to: 866-880-4532**

The Scott & White Health Plan Pharmacy Department manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

Patient Name:	**Prescriber Name:** **Supervising Physician:**

☐ Pharmacy ☐ Individual prescriber ☐ Provider or specialty group ☐ Facility ☐ Other (please specify)
Q15. Provide name and NPI of the billing entity
Q16. Will the claim for the drug be submitted as a MEDICAL claim or PHARMACY claim (Note: If a pharmacy will be submitting a MEDICAL claim for drug reimbursement, answer MEDICAL)? ☐ Medical ☐ Pharmacy
Q17. Additional Comments

_______________________________________ _______________________________

Prescriber Signature Date

☐ Expedited/Urgent - By checking this box and signing above, I certify that applying the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function

Lack of the necessary documentation may result in a medical necessity denial. Requesting providers may speak to a SWHP pharmacist or medical director at 1-800-728-7947 regarding the case to have an opportunity to help impact the decision on a request before coverage has been decided.

This telecopy transmission contains confidential information belonging to the sender that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party. If you are not the intended recipient, you are

PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Cinryze

Phone: 800-728-7947 Fax back to: 866-880-4532

The Scott & White Health Plan Pharmacy Department manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

Patient Name:	**Prescriber Name:** **Supervising Physician:**

hereby notified that any disclosure, copying, distribution or action taken in reference to the contents of this document is strictly prohibited. If you have received this telecopy in error, please notify the sender immediately to arrange for the return of this document