



# Hereditary Angioedema Injectable Medication Precertification Request

**Aetna Precertification Notification**  
503 Sunport Lane, Orlando, FL 32809  
Phone: 1-866-503-0857  
FAX: 1-888-267-3277

Please indicate:  Start of treatment  Continuation of therapy, date of last treatment \_\_\_\_\_ **Today's date:** \_\_\_\_\_  
**Date needed:** \_\_\_\_\_

**Dispensing Provider:**  Aetna Specialty Pharmacy® or  Other: \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ **TIN:** \_\_\_\_\_ **PIN:** \_\_\_\_\_

**Ship to:**  Doctor's office  Patient  Other: \_\_\_\_\_ Phone: \_\_\_\_\_

**Precertification Requested By:** \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

### A. PATIENT INFORMATION

First Name:		Last Name:	
Address:		City:	State: ZIP:
Home Phone:	Work Phone:	Cell Phone:	
DOB:	Allergies:	Email:	
Patient Current Weight: _____ lbs or _____ kgs		Patient Height: _____ inches or _____ cms	

### B. INSURANCE INFORMATION

Aetna Member ID #: _____	Does patient have other coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No
Group #: _____	If yes, provide ID#: _____ Carrier Name: _____
Insured: _____	Insured: _____
Medicare: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide ID #: _____	Medicaid: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide ID #: _____

### C. PRESCRIBER INFORMATION

First Name:		Last Name:		(Circle one): M.D. D.O. N.P. P.A.	
Address:		City:	State:	ZIP:	
Phone:	Fax:	St. Lic. #:	NPI #:	DEA #:	UPIN:
Provider Email:		Office Contact Name:		Phone:	
Specialty : <input type="checkbox"/> Allergy <input type="checkbox"/> Immunology <input type="checkbox"/> Other: _____					

### D. DIAGNOSIS INFORMATION

Primary ICD-9: **277.6**  Type 1  Type 2  Unknown Type Date of Diagnosis: \_\_\_\_\_  
Secondary ICD-9: \_\_\_\_\_ Other ICD-9 Code: \_\_\_\_\_

### E. CLINICAL INFORMATION

Check appropriate box next to the medication that is being requested (see CPB: 0782):  
 **Cinryze** (C1-estrase inhibitor)  **Berinert** (C1-estrase inhibitor, human)  **Kalbitor** (escallantide)  **Firazyr** (icatibant)

**Laboratory Criteria: (Applies to all)**  
 Patient has a diagnosis of HAE documented based on evidence of:  
 Yes  No Normal C1 level and a low C4 level (C4 < 14 mg/dL; or C4 below the lower limit of normal as defined by the laboratory performing the test) **plus one of the following:**  
 Yes  No Low C1 inhibitor (C1INH) antigenic level (C1INH < 19 mg/dL; or C1INH antigenic level below the lower limit of normal as defined by the laboratory performing the test; **or**  
 Yes  No Normal C1INH antigenic level (C1INH ≥ 19mg/dL) and a low C1INH functional level (functional C1INH < 50% or C1INH functional level below the lower limit of normal as defined by the laboratory performing the test; **or**  
 Yes  No A known HAE-causing C1INH mutation (**refers to Cinryze only**)

**Clinical Criteria for Cinryze**  
 Yes  No Patient has a history of at least 2 HAE attacks per month  
 Yes  No Patient has tried and failed or is intolerant to or has a contraindication to 17 alpha-alkylated androgens (e.g., danazol, oxandrolone and stanozolol) or anti-fibrinolytic agents (e.g., epsilon aminocaproic acid, tranexamic acid) for HAE prophylaxis

**Clinical Criteria for Berinert, Kalbitor or Firazyr**  
 Yes  No Patient must be experiencing at least one symptom of moderate or severe attack (e.g., airway swelling, severe abdominal pain, facial swelling, nausea and vomiting, painful facial distortion)

### F. PRESCRIPTION – To be completed for precertification request. Prescriptions will be forwarded to Aetna Specialty Pharmacy unless otherwise noted.

MEDICATION	PRECERT	ASRx DISPENSING?	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
<input type="checkbox"/> Firazyr (icatibant) CPB # 0782	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No				

**\*If Aetna Specialty Pharmacy is the dispensing pharmacy, patient benefits will be verified before product is shipped.**  
**\*If the prescriber is providing the drug, the provider must verify benefits.**  
 Prescriber's Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 (Required by law if Aetna Specialty Pharmacy is the dispensing pharmacy.)  
 Interchange is mandated unless practitioner writes the words "BRAND MEDICALLY NECESSARY" in this space: \_\_\_\_\_