Premier Health Plan
Pharmacy Services
Phone: 866-822-2714
Fax: 855-862-6518

CINRYZE
Prior Authorization Form

□ Standard Request (72 hours) □ 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 □ 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. J CODE:_____ ICD-10 Code:_____	Place of Administration: □ Physician's Office □ Hospital/Clinic □ 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: