PriorityHealth

Pharmacy Prior Authorization Form

For Prior Authorization, please fax to: 877 974-4411 toll free, or 616 942-8206

This form applies to: ☒ **Commercial** ☒ **Commercial Individual (PPACA)** ☐ **Medicaid**

This request is: ☐ **Urgent** (life threatening) ☐ **Non-Urgent** (standard review)

Urgent means the standard review time may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function. The standard review time averages between 1 and 3 business days.

Ruconest® (recombinant c1 esterase inhibitor)

Reset Form

Member

Last Name: _____ First Name: _____

ID #: _____ DOB: _____ Gender: _____

Primary Care Physician: _____

Requesting Provider: _____ Prov. Phone: _____ Prov. Fax: _____

Provider Address: _____

Provider NPI: _____ Contact Name: _____

Date: _____

Product Information

☐ New request ☐ Continuation request

Drug product: ☐ Ruconest 2,100 unit vial

Start date (or date of next dose): _____

Date of last dose (if applicable): _____

Dosing frequency: _____

Drug cost information

The wholesale acquisition cost for each 2,100 IU vial of Ruconest is $5,708.31. The annual cost of treatment with this drug will vary depending on the patient's circumstances.

Precertification Requirements

Before this drug is covered, the patient must meet all of the following requirements:

1. Diagnosis of hereditary angioedema type I or type II
    a. Requires submission of two sets of C4, C1-INH protein, and C1-INH function lab results confirming diagnosis.
2. Greater than 12 years old
3. Patient has received training for self-administration
4. Ruconest is being used only for the treatment of acute attacks
5. Patient has had a documented trial of acute therapy with Firazyr
    a. This requirement may be waived if patient has been previously maintained on Ruconest for ≥ six months.
6. Patient has failed one previous optimized prophylactic treatment (e.g. danazol 600 mg total daily dose)
7. Ruconest authorization is limited to one fill of two vials. Each additional fill requires documentation of the patient's use of the previous supply of Ruconest and only the number of vials used will be replaced.

NOTE: Priority Health may require you get a second opinion confirming your diagnosis prior to covering this medication.

All fields must be complete and legible for review. Your office will receive a response via fax. No changes made since 05/2017

Last reviewed 05/2017

New request
Priority Health Precertification Documentation

A. What condition is this drug being requested for?

☐ Hereditary angioedema type I or II (two sets of C4, C1-INH protein, and C1-INH function lab results must be submitted to Priority Health)

☐ *Other – the patient's condition is:* _____

Rationale for use: _____

B. Has the patient received self-administration training?

☐ Yes

☐ No

C. Will the patient being using Ruconest for acute or prophylactic treatment?

☐ Acute

☐ Prophylactic

D. Has the patient had a trial of Firazyr for acute attacks?

☐ Yes

☐ No

Rationale for use: _____

Request to continue a previously authorized approval
Priority Health Precertification Documentation

A. What was the date of use for the supply of Ruconest dispensed? (Please provide accompanying documentation)_____

_____

_____

Additional information

Note: The recommended dose of Ruconest is based on the patient's weight (see below). Ruconest is not covered in combination with Firazyr, Berinert, or Kalbitor.

Body Weight	RUCONEST Dose for Intravenous Injection
< 84 kg	50 U per kg
≥ 84 kg	4,200 U (2 vials)

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Last reviewed 05/2017