UnitedHealthcare Community Plan

Cinryze - Nebraska

PRIOR AUTHORIZATION REQUEST FORM

Please complete this entire form and fax it to: **866-940-7328**. If you have questions, please call **800-310-6826.**
This form contains multiple pages. Please complete all pages to avoid a delay in our decision.
Allow at least 24 hours for review.

Section A – Member Information

First Name:	Last Name:	Member ID:
Address:		
City:	State:	ZIP Code:
Phone:	DOB:	Allergies:
Primary Insurance Information:		

Is the requested medication □ New or □ Continuation of Therapy? If continuation, list start date: _____

Is this patient currently hospitalized? □ Yes □ No If recently discharged, list discharge date: _____

Section B - Provider Information

First Name:		Last Name:		M.D./D.O.
Address:		City:	State:	ZIP code:
Phone:	Fax:	NPI #:	Specialty:	
Office Contact Name / Fax attention to:				

Section C - Medical Information

Medication:	**Strength:**
Directions for use:	**Quantity:**
Diagnosis (Please be specific & provide as much information as possible)**:**	**ICD-10 CODE:**

Is this member pregnant? □ Yes □ No If yes, what is this member's due date? _____

Section D – Previous Medication Trials

Medications	Strength	Directions	Dates of Therapy	Reason for failure / discontinuation

Section E – Additional information and Explanation of why preferred medications would not meet the patient's needs: Please refer to the patient's PDL for a list of preferred alternatives

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Member First name:	Member Last name:	Member DOB:

Clinical and Drug Specific Information

ALL REQUESTS	
□ **Yes** □ **No**	**Does the patient have a diagnosis of hereditary angioedema (HAE) as confirmed by any of the following?** *(If yes, check which applies)* □ Confirmed monoallelic mutation known to cause HAE in either the SERPING1 or F12 gene □ A C4 level below the lower limit of normal and one of the following (per laboratory standard): C1 inhibitor (C1-INH) antigenic level below the lower limit of normal OR C1-INH functional level below the lower limit of normal
□ **Yes** □ **No**	**Will Cinryze be used for any of the following?** *(If yes, check which applies)* □ Prophylaxis against HAE attacks □ Treatment of acute HAE attacks (off-label)
□ **Yes** □ **No**	**Is Cinryze prescribed by one of the following?** *(If yes, check which applies)* □ Immunologist □ Allergist □ Rheumatologist
PROPHYLAXIS AGAINST HAE ATTACKS	
□ **Yes** □ **No**	**Will Cinryze be used in combination with other approved C1 esterase inhibitors indicated for prophylaxis against HAE attacks (e.g., Haegarda)?** *If yes, list medication and rationale:*
□ **Yes** □ **No**	**Does the prescriber attest that the patient has experienced attacks of a severity and/or frequency such that they would clinically benefit from prophylactic therapy with Cinryze?**
TREATMENT OF ACUTE HAE ATTACKS	
□ **Yes** □ **No**	**Will Cinryze be used on combination with other approved treatments for acute HAE attacks (e.g. Berinert, Firazyr, Kalbitor or Ruconest)?** *If yes, list medication and rationale:*

Physician Signature: _____ **Date:** _____

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