

UPMC HEALTH PLAN

CINRYZE

Prior Authorization Form

IF THIS IS AN URGENT REQUEST, Please Call UPMC Health Plan Pharmacy Services.

Otherwise please return completed form to:

UPMC HEALTH PLAN PHARMACY SERVICES PHONE 800-979-UPMC (8762)

FAX 412-454-7722

PLEASE TYPE OR PRINT NEATLY

Please complete all sections of this form AND include details of past relevant medical treatment, which substantiates the need for an exception to using formulary alternatives, i.e. past prescription treatment failures, documented side effects, chart documentation, lab values, etc. Incomplete responses may delay this request.

Office Contact:		Provider Specialty:	
Provider First Name:		Provider Last Name:	
Provider Phone:		Provider Fax:	
Patient Name:	Patient UPMC Health Plan ID Number:	Patient DOB:	Patient Age:
Drug Requested:	Strength:	Frequency:	Qty Dispensed:
<input type="checkbox"/> New medication <input type="checkbox"/> Ongoing medication	If ongoing, provide date started:	If medication is ongoing, Did member show improvement while on therapy?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diagnosis:		Date of diagnosis:	

Medical History

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

Please list reason for discontinuation: _____

The member must have a diagnosis of HAD 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

Copy of lab report with reference ranges is required.

Chart documentation of each HAE attack is required.
Please include number of attacks per month and attack severity.

Chart documentation sent? Yes No