

**PREAUTHORIZATION FORM**  
 Cinryze<sup>®</sup>, Berinert<sup>®</sup>, Kalbitor<sup>®</sup>, and Firazyr<sup>®</sup>  
 (C1 Esterase Inhibitor [Human], Ecallantide, and Icatibant)

**Therapeutic use:**

- Cinryze is used for routine prevention against hereditary angioedema (HAE) attacks
- Berinert, Kalbitor, and Firazyr are used for the treatment of acute abdominal or facial attacks of hereditary angioedema (HAE)

**Quantity Limit:**

- Cinryze: Not to exceed 2000 units weekly; dosing is 1000 units IV over 10 minutes every 3-4 days
- Berinert: Not to exceed a single dose of 20 units/kg IV at 4 ml/min
- Kalbitor: Not to exceed 60 mg within a 24 hour period
- Firazyr: Not to exceed 90 mg within a 24 hour period

**Authorization Period:** 6 months initially

Patient's name \_\_\_\_\_

Patient's ID# [ ][ ][ ][ ][ ][ ][ ][ ][ ][ ] DOB [ ][ ] / [ ][ ] / [ ][ ][ ][ ][ ]

ICD-9 [ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]

Physician's name \_\_\_\_\_

Physician's Ph# ( [ ][ ][ ][ ] ) [ ][ ][ ][ ] - [ ][ ][ ][ ][ ] Fax# [ ][ ][ ][ ] - [ ][ ][ ][ ][ ]

Physician's signature \_\_\_\_\_ Date signed [ ][ ] / [ ][ ] / [ ][ ][ ][ ][ ]

Supervising Physician's name \_\_\_\_\_ (Required if requesting provider is a nurse practitioner or physician assistant)

Please check "Yes" or "No" and respond to the following requests:					
1.	Which medication is being requested?	<input type="checkbox"/> Cinryze	<input type="checkbox"/> Berinert	<input type="checkbox"/> Kalbitor	<input type="checkbox"/> Firazyr
2.	Is the prescribing physician an Allergist or Immunologist who evaluates and treats HAE?	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
3.	Does the patient have a diagnosis HAE?	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
If requesting routine prevention of HAE attacks with Cinryze:					
4a.	Does the patient have a history of ≥ 2 HAE attacks per month?	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
4b.	Is the patient compliant with trigger avoidance?	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
4c.	Has the patient had an adequate trial of androgen therapy or is there a contraindication to androgen therapy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
4d.	Is the patient scheduled to undergo a major medical procedure requiring prophylaxis?	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
If requesting treatment of acute HAE attacks with Berinert, Kalbitor or Firazyr:					
5a.	Has the patient experienced an acute moderate to severe abdominal or facial HAE attack?	<input type="checkbox"/> Yes	<input type="checkbox"/> No		

**This form is intended for SelectHealth members only. All requests for preauthorization should be sent via fax to 1-801-442-3006. Missing, inaccurate, or incomplete information may cause a delay or denial of authorization.**