Kalbitor (*ecallantide*)

Fax completed form to: (855) 840-1678
If this is an URGENT request, please call (800) 882-4462
(800.88.CIGNA)

PHYSICIAN INFORMATION			PATIENT INFORMATION		
* Physician Name:			*Due to privacy regulations we will not be able to respond via fax with the outcome of our review unless all asterisked (*) items on this form are completed.*		
Specialty:	* DEA, NPI or TIN:				
Office Contact Person:			* Patient Name:		
Office Phone:			* Cigna ID:	* Date of Birth:	
Office Fax:			* Patient Street Address:		
Office Street Address:			City:	State:	Zip:
City:	State:	Zip:	Patient Phone:		

Urgency:
☐ Standard ☐ Urgent (In checking this box, I attest to the fact that applying the standard review time frame may seriously jeopardize the customer's life, health, or ability to regain maximum function)

Medication requested:
☐ Kalbitor 30mg/3ml vial

Directions for use: Quantity: Duration of therapy: J-Code:

Is this a new start or continuation of therapy with the requested drug
☐ new start of therapy ☐ continuation of therapy:

Where will this medication be obtained?
☐ Accredo Specialty Pharmacy**
☐ Hospital Outpatient
☐ Retail pharmacy
☐ Other (please specify):
☐ Home Health / Home Infusion vendor
☐ Physician's office stock (billing on a medical claim form)
***Cigna's nationally preferred specialty pharmacy*

***Medication orders can be placed with Accredo via E-prescribe - Accredo (1620 Century Center Pkwy, Memphis, TN 38134-8822 | NCPDP 4436920), Fax 888.302.1028, or Verbal 866.759.1557*

Facility and/or doctor dispensing and administering medication:
Facility Name: State: Tax ID#:
Address (City, State, Zip Code):

Where will this drug be administered?
☐ Patient's Home
☐ Hospital Outpatient
☐ Physician's Office
☐ Other (please specify):

***NOTE:** Per some Cigna plans, infusion of medication MUST occur in the least intensive, medically appropriate setting.*
Is this patient a candidate for re-direction to an alternate setting (such as alternate infusion site, physician's office, home) with assistance of a Specialty Care Options Case Manager? ☐ Yes ☐ No (provide medical necessity rationale):

Is the requested medication for a chronic or long-term condition for which the prescription medication may be necessary for the life of the patient? ☐ Yes ☐ No

Diagnosis related to use:
☐ Hereditary angioedema (HAE) due to C1 inhibitor (C1-INH) deficiency (Please note: A diagnosis of HAE with normal C1-INH [also known as HAE type III] does NOT satisfy this requirement)
☐ other

Clinical Information:

(if HAE due to C1-INH deficiency) What type of hereditary angioedema (HAE) does the patient have?
☐ HAE due to C1 esterase inhibitor deficiency, type I
☐ HAE due to C1 esterase inhibitor deficiency, type II
☐ Other

(if HAE due to C1-INH deficiency type I or II) What is the indication being requested?
☐ Treatment of acute hereditary angioedema (HAE) type I or type II attacks
☐ Prophylaxis of hereditary angioedema (HAE) attacks
☐ Other

(if treatment) Has the patient treated previous acute Hereditary Angioedema (HAE) attacks with Kalbitor? ☐ Yes ☐ No

(if treated previous attacks) Has the patient had prior approval through the Coverage Review Department for this product? Please note: If the patient is currently receiving the requested therapy but has not previously received approval of Kalbitor for this specific indication through the Coverage Review Department, review under criteria for Initial Therapy (answer "No" to this question). ☐ Yes ☐ No

(if prior approval through CRD) Is documentation being provided to confirm the patient's Hereditary Angioedema (HAE) (type I or type II) diagnosis? Please note: A diagnosis of HAE with normal C1-INH (also known as HAE type III) does NOT satisfy this requirement. PLEASE NOTE: Medical documentation specific to your response must be attached to this case or your request may be denied. Documentation may include, but is not limited to, chart notes, laboratory results, medical test results, claims records, prescription receipts, and/or other information. All documentation must include patient-specific identifying information. ☐ Yes ☐ No

(if prior approval through CRD) According to the prescriber, has the patient had a favorable clinical response with Kalbitor being used as treatment? Please Note: Examples of favorable clinical response include decrease in the duration of HAE attacks, quick onset of symptom relief, complete resolution of symptoms, or decrease in HAE acute attack frequency or severity. ☐ Yes ☐ No

(if prior approval through CRD) Is this medication being prescribed by, or in consultation with, an allergist/immunologist or a physician who specializes in the treatment of Hereditary Angioedema (HAE) or related disorders? ☐ Yes ☐ No

(if no treated previous attacks OR no prior approval through CRD) Is this medication being prescribed by, or in consultation with, an allergist/immunologist or a physician who specializes in the treatment of Hereditary Angioedema (HAE) or related disorders? ☐ Yes ☐ No

(if no treated previous attacks OR no prior approval through CRD) Is documentation being provided to show that the patient's Hereditary Angioedema (HAE) (type I or type II) has been confirmed by low levels of functional C1-INH protein (less than 50% of normal) at baseline, as defined by the laboratory reference values? PLEASE NOTE: Medical documentation specific to your response must be attached to this case or your request may be denied. Documentation may include, but is not limited to, chart notes, laboratory results, medical test results, claims records, prescription receipts, and/or other information. All documentation must include patient-specific identifying information. ☐ Yes ☐ No

(if no treated previous attacks OR no prior approval through CRD) Is documentation being provided to show that the patient's Hereditary Angioedema (HAE) (type I or type II) has been confirmed by lower than normal serum C4 levels at baseline, as defined by the laboratory reference values? PLEASE NOTE: Medical documentation specific to your response must be attached to this case or your request may be denied. Documentation may include, but is not limited to, chart notes, laboratory results, medical test results, claims records, prescription receipts, and/or other information. All documentation must include patient-specific identifying information. ☐ Yes ☐ No

(if 18 or older) Has the patient previously treated an acute Hereditary Angioedema (HAE) attack with Kalbitor? ☐ Yes ☐ No

(if no) Has the patient tried generic icatibant? Please Note: A previous trial of any icatibant product would count. ☐ Yes ☐ No

Additional pertinent information:

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan or insurer its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature:_____ **Date:**_____

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