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

Ruconest
(*recombinant C1 esterase inhibitor)*

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:
☐ Ruconest 2100 unit vial

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

What is the patient's current weight (kg)? ICD10:

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

Clinical Information:

What type of hereditary angioedema (HAE) does the patient have? Please Note: A diagnosis of HAE with normal C1-INH (also known as HAE type III) does NOT satisfy this requirement.
☐ HAE due to C1 inhibitor deficiency, type I
☐ HAE due to C1 inhibitor deficiency, type II
☐ Other

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

(if treatment) Has the patient been treated for previous acute HAE attacks with Ruconest? ☐ Yes ☐ No

(if previously treated) Is documentation being provided to confirm the patient's diagnosis of HAE type I or type II? 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 to this question must be attached to this case or your request could 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 previously treated) According to the prescriber, has the patient had a favorable clinical response with Ruconest treatment? 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 previously treated) Is the requested medication prescribed by or in consultation with an allergist/immunologist or a physician who specializes in the treatment of HAE or related disorders? ☐ Yes ☐ No

(if initial therapy) 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 to this question must be attached to this case or your request could 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 initial therapy) 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 to this question must be attached to this case or your request could 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 initial therapy) Is the requested medication being prescribed by, or in consultation with, an allergist/immunologist? ☐ 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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Our standard response time for prescription drug coverage requests is 5 business days. If your request is urgent, it is important that you call us to expedite the request. View our Prescription Drug List and Coverage Policies online at cigna.com.

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