Prescriber Criteria Form

Icatibant 2026 PA Fax 809-A v1 010126.docx
Firazyr, Sajazir (icatibant)
Coverage Determination

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673.** Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Icatibant.

Drug Name (select from list of drugs shown):

Patient Name:		
Patient ID:		
Patient DOB:	**Patient Phone:**	
Prescriber Name:		
Prescriber Address:		
City:	**State:**	**Zip:**
Prescriber Phone:	**Prescriber Fax:**	
Diagnosis:	**ICD Code(s):**	

Please circle the appropriate answer for each question.			
1	Does the patient have a diagnosis of hereditary angioedema (HAE)? [If no, then no further questions.]	Yes	No
2	Does the patient have hereditary angioedema with C1 inhibitor deficiency or dysfunction confirmed by laboratory testing? [If yes, then skip to question 6.]	Yes	No
3	Does the patient have hereditary angioedema with normal C1 inhibitor confirmed by laboratory testing? [If no, then no further questions.]	Yes	No
4	Did the patient test positive for an F12, angiopoietin-1, plasminogen, kininogen-1 (KNG1), heparan sulfate-glucosamine 3-O-sulfotransferase 6 (HS3ST6), or myoferlin (MYOF) gene mutation? [If yes, then skip to question 6.]	Yes	No
5	Does the patient meet both of the following conditions: A) patient has a family history of angioedema, B) the angioedema was refractory to a trial of high-dose antihistamine therapy for at least one month? [If no, then no further questions.]	Yes	No
6	Is the requested drug being used for the treatment of acute angioedema attacks? [If no, then no further questions.]	Yes	No

7	Is the patient 18 years of age or older? [If no, then no further questions.]	Yes	No
8	Is the requested drug being prescribed by or in consultation with an immunologist, allergist, or rheumatologist?	Yes	No

Comments:	_____

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.
Prescriber (or Authorized) Signature: _____ **Date:**_____