Kalbitor® (ecallantide) Medication Precertification Request

(All fields must be completed and legible for precertification review.)

Aetna Precertification Notification
Phone: 1-866-752-7021
FAX: 1-888-267-3277

For Medicare Advantage Part B: Please Use Medicare Request Form

Please indicate: ☐ Start of treatment: Start date ____/____/____
☐ Continuation of therapy: Date of last treatment ____/____/____

Precertification Requested By: ______________________ Phone: ______________ Fax: ______________

A. PATIENT INFORMATION

First Name: | Last Name:
Address: | City: | State: | ZIP:
Home Phone: | Work Phone: | Cell Phone:
DOB: | Allergies: | Email:
Current Weight: ________ lbs or ________ kgs Height: ________ inches or ________ cms

B. INSURANCE INFORMATION

Aetna Member ID #: ______________________
Group #: ______________________
Insured: ______________________

Does patient have other coverage? ☐ Yes ☐ No
If yes, provide ID#: ______________ Carrier Name: ______________________
Insured: ______________________

Medicare: ☐ Yes ☐ No If yes, provide ID #: ______________ **Medicaid**: ☐ Yes ☐ No If yes, provide ID #: ______________

C. PRESCRIBER INFORMATION

First Name: | Last Name: | *(Check One)*: ☐ M.D. ☐ D.O. ☐ N.P. ☐ P.A.
Address: | City: | State: | ZIP:
Phone: | Fax: | St Lic #: | NPI #: | DEA #: | UPIN:
Provider Email: | Office Contact Name: | Phone:

Specialty *(Check one)*: ☐ **Allergist** ☐ **Immunologist** ☐ **Other**: ______________________

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration:
☐ Self-administered ☐ Physician's Office
☐ Outpatient Infusion Center Phone: ______________
Center Name: ______________________
☐ Home Infusion Center Phone: ______________
Agency Name: ______________________
☐ Administration code(s) (CPT): ______________
Address: ______________________

Dispensing Provider/Pharmacy: *(Patient selected choice)*
☐ Physician's Office ☐ Retail Pharmacy
☐ Specialty Pharmacy ☐ Other: ______________
Name: ______________________
Address: ______________________
Phone: ______________ Fax: ______________
TIN: ______________ PIN: ______________

E. PRODUCT INFORMATION

Request is for: Kalbitor (ecallantide) Dose: ______________ **Frequency:** ______________

F. DIAGNOSIS INFORMATION – Please indicate primary ICD Code and specify any other where applicable.

Primary ICD Code: ______________ Secondary ICD Code: ______________ Other ICD Code: ______________

G. CLINICAL INFORMATION – Required clinical information must be completed in its entirety for all precertification requests.

For All Requests (clinical documentation required for all requests):

☐ Yes ☐ No Is the requested drug being used for the treatment of acute hereditary angioedema (HAE) attacks?
☐ Yes ☐ No Will the requested drug be used in combination with any other medication used for treatment of acute hereditary angioedema (HAE) attacks (e.g., Berinert, Firazyr, Ruconest)?
☐ Yes ☐ No Is the requested medication prescribed by or in consultation with a prescriber who specializes in the management of hereditary angioedema (HAE)?

Which of the following applies to the patient at the time of diagnosis?

☐ **Hereditary angioedema (HAE) with C1 inhibitor deficiency or dysfunction confirmed by laboratory testing**
Please indicate which of the following conditions the patient has/had at the time of diagnosis:
- ☐ A C1 inhibitor (C1-INH) antigenic level below the lower limit of normal as defined by the laboratory performing the test
- ☐ A normal C1-INH antigenic level and a low C1-INH functional level (functional C1-INH less than 50% or C1-INH functional level below the lower limit of normal as defined by the laboratory performing the test)
- ☐ Other

☐ **Hereditary angioedema (HAE) with normal C1 inhibitor confirmed by laboratory testing**
Please indicate which of the following conditions the patient has/had at the time of diagnosis:
- ☐ F12, angiopoietin-1, plasminogen, kininogen-1 (KNG1), heparan sulfate-glucosamine 3-0 sulfotransferase 6 (HS3ST6) or myoferlin (MYOF) gene mutation as confirmed by genetic testing
- ☐ **Both** of the following: 1). Angioedema refractory to a trial of high-dose antihistamine therapy (i.e., cetirizine at 40 mg per day or the equivalent) for at least one month **AND** 2). Family history of angioedema
- ☐ Other

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Patient First Name	Patient Last Name	Patient Phone	Patient DOB

G. CLINICAL INFORMATION *(continued)* – Required clinical information must be completed in its entirety for all precertification requests.

For Continuation of Therapy Requests (clinical documentation required for all requests):

☐ Yes ☐ No Has the patient experienced a reduction in severity and/or duration of acute attacks?

☐ Yes ☐ No Does the patient's attack frequency, attack severity, comorbid conditions and patient's quality of life warrant prophylactic therapy?

→ ☐ Yes ☐ No Has prophylactic treatment been considered?

→ Please provide a brief rationale as to why prophylactic treatment has not been considered: ____________________

H. ACKNOWLEDGEMENT

Request Completed By *(Signature Required)*: ______________________________ **Date:** ____/____/____

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

The plan may request additional information or clarification, if needed, to evaluate requests.