



**MEDICARE ADVANTAGE
PRIOR AUTHORIZATION REQUEST FORM**

Cinryze - Medicare

Phone: 215-991-4300

Fax back to: 866-371-3239

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Member Name:	Prescriber Name:	
Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Line of Business: <input type="checkbox"/> Medicare Advantage	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that applying the 72 hour standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Drug Name:	
Strength:	
Directions / SIG:	

**Please attach any pertinent medical history including labs and information for this member that may support approval.
Please answer the following questions and sign.**

<p>Q1. Has the patient been previously approved for Cinryze? If YES, go to 2. If NO, go to 3</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q2. Is there confirmation that the patient has had a reduction in severity or duration of attacks?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q3. Does the patient have a documented diagnosis of hereditary angioedema (HAE)?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q4. Is there confirmation that Cinryze is being used for the prophylaxis of hereditary angioedema (HAE)?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q5. Is the member taking Cinryze in combination with another approved treatment for prophylaxis against HAE attacks?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>



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Member Name:	Prescriber Name:
Q6. Is the patient 6 years of age or older <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q7. Is Cinryze being prescribed by or in consultation with an allergist, immunologist, pulmonologist or prescriber who specializes in the treatment of HAE? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q8. Does the prescriber want to have the medication provided by a pharmacy and covered under Medicare Part D? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q9. Requested Duration: <input type="checkbox"/> 12 Months <input type="checkbox"/> Other:	
Q10. Additional Information:	

Prescriber Signature

Date

v2025