

HEREDITARY ANGIOEDEMA PRIOR AUTHORIZATION REQUEST PRESCRIBER FAX FORM

Only the prescriber may complete this form. This form is for prospective, concurrent, and retrospective reviews.

The following documentation is **REQUIRED**. Incomplete forms will be returned for additional information. For formulary information please visit www.myprime.com. Start saving time today by filling out this form electronically. Visit covermymeds.com to begin using this free service.

What is the priority level of this request?

- Standard review
- Expedited/Urgent review – prescriber certifies that waiting for a standard review could seriously harm the patient's life, health or ability to regain maximum function

Today's Date: _____

PATIENT AND INSURANCE INFORMATION

Date of Service (if differs from Today's Date): _____

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
Patient Address:	City, State, Zip:	Patient Telephone:	
Member ID Number:	Group Number:		

PRESCRIBER/CLINIC INFORMATION

Prescriber Name:	Prescriber NPI#:	Specialty:	Contact Name:
Clinic Name:	Clinic Address:		
City, State, Zip:	Phone #:	Secure Fax #:	

PLEASE ATTACH ANY ADDITIONAL INFORMATION THAT SHOULD BE CONSIDERED WITH THIS REQUEST

Patient's Diagnosis: <input type="checkbox"/> Hereditary angioedema (HAE) due to C1INH deficiency [HAE-C1INH (Type 1)] <input type="checkbox"/> Hereditary angioedema (HAE) due to C1INH deficiency [HAE-C1INH (Type 2)] <input type="checkbox"/> Hereditary angioedema (HAE) with normal C1INH (HAE-nl-C1INH) <input type="checkbox"/> Other (ICD code, plus description): _____	
Medication Requested:	Strength:
Dosing Schedule:	Quantity per Month:
For all requests: 1. What is the patient's weight? _____ (kg) 2. Is the patient currently being treated with the requested agent?..... <input type="checkbox"/> Yes <input type="checkbox"/> No 3. Does the patient have any FDA labeled contraindications to the requested agent?..... <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please specify FDA labeled contraindications: _____ 4. Is the prescriber a specialist in the area of the patient's diagnosis (e.g., allergist or immunologist), or has the prescriber consulted with a specialist in the area of the patient's diagnosis? <input type="checkbox"/> Yes <input type="checkbox"/> No 5. Have medications known to cause angioedema (i.e., ACE-Inhibitors, estrogens, angiotensin II receptor blockers) been evaluated and discontinued when appropriate? <input type="checkbox"/> Yes <input type="checkbox"/> No 6. Is the patient's age within FDA labeling for the requested indication for the requested agent?..... <input type="checkbox"/> Yes <input type="checkbox"/> No If no, please provide support for using the requested agent for the patient's age for the requested indication: _____ 7. Please list all reasons for selecting the requested agent for the indicated diagnosis, strength, dosing schedule, and quantity over alternatives (e.g., compendia support, journal articles, contraindications, allergies, history of adverse drug reactions to alternatives, lower dose has been tried, information supporting dose over FDA max). Please note, documentation may be required: _____ _____ _____	
For Haegarda requests: 8. Please specify quantity of each vial strength per 28 days: 2000 IU vials: _____ 3000 IU vials: _____	
Please continue to the next page.	

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
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For Berinert, Ekterly, Firazyr, icatibant, or Ruconest requests:

9. Has the patient been treated with the requested agent (starting on samples is not approvable)? Yes No
 If yes, is the patient at risk if therapy is changed? Yes No
 If yes, please specify risk: _____
10. Will the requested agent be used to treat acute HAE attacks? Yes No
11. Will the patient be using the requested agent in combination with another agent indicated for the treatment of acute HAE attacks (i.e., Berinert, Ekterly, Firazyr, icatibant, Kalbitor, Ruconest)? Yes No
12. Is there support for therapy with a higher dose or quantity? (e.g., frequency of attacks within the past 3 months has been greater than 2 attacks per month) Yes No
 If yes, please provide supporting information: _____
13. If the diagnosis is HAE-C1INH Type 1, please answer the following questions:
 a. Has the patient's diagnosis has been confirmed with decreased quantities of C4 level, C1-INH protein level, and C1-INH function level? Yes No
 b. Has the patient's diagnosis been confirmed by a mutation in the C1-INH gene altering protein synthesis and/or function? Yes No
14. If the patient's diagnosis is HAE-C1INH Type 2, please the answer the following questions:
 a. Has the patient's diagnosis has been confirmed with decreased quantities of C4 level and C1-INH function level (C1-INH protein level may be normal or elevated)? Yes .. No
 b. Has the patient's diagnosis been confirmed by a mutation in the C1-INH gene altering protein synthesis and/or function? Yes .. No
15. If the diagnosis is HAE-nl-C1INH, please the answer the following questions:
 a. Has the patient's diagnosis been confirmed by levels within the normal range for C1-INH protein level, C1-INH function level, and C4 level? Yes No
 b. Is the patient's diagnosis associated with a mutation in ONE of the following genes: 1) Coagulation factor FXII (mutation in F12, 2) Plasminogen, 3) Angiopoietin-1, 4) Kininogen1, 5) Heparan sulfate 3-O-sulfotransferase 6 gene, or 6) Myoferlin gene? Yes No
 c. Does the patient have a diagnosis of HAE-U that has been confirmed by an HAE specialist? **Please note, medical records are required.** Yes No

For Andembry, Cinryze, Dawnzera, Haegarda, Orladeyo, or Takhzyro requests:

16. Has the patient been treated with the requested agent within the past 90 days (starting on samples is not approvable)? Yes No
 If yes, is the patient at risk if therapy is changed? Yes No
 If yes, please specify risk: _____
17. Will the patient be using the requested agent in combination with another agent indicated for prophylaxis of HAE attacks (i.e., Andembry, Cinryze, Dawnzera, Haegarda, Orladeyo, Takhzyro)? Yes No
18. Is the requested agent being prescribed for HAE prophylaxis? Yes No
19. Does the patient have a history of at least three moderate to severe acute HAE attacks per month (e.g., airway swelling, severe abdominal pain, painful facial swelling)? Yes No
20. Please give information in support of therapy with a higher dose or quantity: _____
21. If the diagnosis is HAE-C1INH Type 1, please answer the following questions:
 a. Has the patient's diagnosis been confirmed by decreased quantities of C4 level, C1-INH protein level, and C1-INH function level? Yes No
 b. Has the patient's diagnosis been confirmed by a mutation in the C1-INH gene altering protein synthesis and/or function? Yes No
22. If the diagnosis is HAE-C1INH Type 2, please answer the following questions:
 a. Has the patient's diagnosis been confirmed by a mutation in the C1-INH gene altering protein synthesis and/or function? Yes No
 b. Has the patient's diagnosis been confirmed by decreased quantities of C4 level and C1-INH function level (C1-INH protein level may be normal or elevated)? Yes No

For Dawnzera requests:

23. Is the patient initiating therapy with the requested agent? Yes No
 If no, has the patient been treated with the requested agent for less than 12 consecutive months? Yes No
 If no, has the patient been free of acute HAE attacks for at least 12 consecutive months? Yes No
 If yes, will the patient's dose be reduced to 80 mg every 8 weeks? Yes No
 If no, please give support for therapy using 80 mg every 4 weeks: _____

Please continue to the next page.

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
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For Takhzyro requests for patients 12 years of age or older:

24. Is the patient initiating therapy with the requested agent? Yes No
 If no, has the patient been treated with the requested agent for less than 6 consecutive months? Yes No
 If no, has the patient been free of acute HAE attacks for at least 6 consecutive months? Yes No
 If yes, will the patient's dose be reduced to 300 mg every 4 weeks? Yes No
 If no, please give support for therapy using 300 mg every 2 weeks: _____

For Takhzyro requests for patients 6 to less than 12 years of age:

25. Is the patient initiating therapy with the requested agent? Yes No
 If no, has the patient been treated with the requested agent for less than 6 consecutive months? Yes No
 If no, has the patient been free of acute HAE attacks for at least 6 consecutive months? Yes No
 If yes, will the patient's dose be reduced to 150 mg every 4 weeks? Yes No
 If no, please give support for therapy using 150 mg every 2 weeks: _____

For Ekterly or Ruconest requests, please submit chart notes to support the answers to the following questions:

26. Is the patient currently being treated with the requested agent, and the patient is currently stable on the requested agent? Yes No
 27. Has the patient tried and had an inadequate response to generic icatibant? Yes No
 28. Was generic icatibant discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? Yes No
 29. Does the patient have an intolerance or hypersensitivity to generic icatibant? Yes No
 30. Does the patient have an FDA labeled contraindication to generic icatibant? Yes No
 31. Is generic icatibant expected to be ineffective based on the known clinical characteristics of the patient and the known characteristics of the prescription drug; or cause a significant barrier to the patient's adherence of care; or worsen a comorbid condition; or decrease the patient's ability to achieve or maintain reasonable functional ability in performing daily activities; or cause an adverse reaction or cause physical or mental harm? Yes No
 32. Is generic icatibant not in the best interest of the patient based on medical necessity? Yes No
 33. Has the patient tried another prescription drug in the same pharmacologic class or with the same mechanism of action as generic icatibant and that prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? Yes No

For brand Firazyr requests, please submit chart notes to support the answers to the following questions:

34. Is the patient currently being treated with the requested agent, and the patient is currently stable on the requested agent? Yes No
 35. Has the patient tried and had an inadequate response to generic icatibant? Yes No
 36. Was generic icatibant discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? Yes No
 37. Does the patient have an intolerance or hypersensitivity to generic icatibant that is not expected to occur with the requested brand agent? Yes No
 38. Does the patient have an FDA labeled contraindication to generic icatibant that is not expected to occur with the requested brand agent? Yes No
 39. Is generic icatibant expected to be ineffective based on the known clinical characteristics of the patient and the known characteristics of the prescription drug; or cause a significant barrier to the patient's adherence of care; or worsen a comorbid condition; or decrease the patient's ability to achieve or maintain reasonable functional ability in performing daily activities; or cause an adverse reaction or cause physical or mental harm? Yes No
 40. Is generic icatibant not in the best interest of the patient based on medical necessity? Yes No
 41. Has the patient tried another prescription drug in the same pharmacologic class or with the same mechanism of action as generic icatibant and that prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? Yes No
 42. Is there support for the use of the requested brand agent over generic icatibant? Yes No
 If yes, please provide supporting information: _____

For Andembry, Cinryze, Dawnzera, Haegarda, Orladeyo, or Takhzyro renewal requests:

43. Has the patient had clinical benefit with the requested agent? Yes No

For Berinert, Ekterly, Firazyr, icatibant, or Ruconest renewal requests:

44. Has the patient had clinical benefit with the requested agent? Yes No
 45. Has the prescriber communicated (via any means) with the patient regarding frequency and severity of attacks AND has verified that the patient does not have greater than a 1-month supply (sufficient for 2 acute HAE attacks) currently on-hand? Yes No

Please continue to the next page.

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
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