



PRIOR AUTHORIZATION REQUEST
Firazyr

PATIENT: Name, Address, City, State, Zip, D.O.B., Member ID
Prescriber: Name, Address, City, State, Zip, Phone, Fax, NPI

Medication Requested: Qty Requested:

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided.

SECTION A: Please answer the following questions

- 1. For which indication is this medication being prescribed?
2. Has the patient treated previous acute Hereditary Angioedema (HAE) attacks with the requested medication?
3. 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 (< 50% of normal) at baseline, as defined by the laboratory reference values?
4. 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?
5. Is documentation being provided to confirm the patient's Hereditary Angioedema (HAE) (type I or type II) diagnosis?
6. According to the prescriber, has the patient had a favorable clinical response (for example, decrease in the duration of HAE attacks, quick onset of symptom relief, complete resolution of symptoms, decrease in HAE acute attack frequency or severity) with the requested medication being used as treatment?
7. Is this medication being prescribed by, or in consultation with, an

If you have any questions, call: 800-753-2851



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allergist/immunologist or a physician who specializes in the treatment of Hereditary Angioedema (HAE) or related disorders?

***Please document the diagnoses, symptoms, and/or any other information important to this review:***

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**SECTION B**      Physician Signature

PHYSICIAN SIGNATURE

DATE

**FAX COMPLETED FORM TO: 877-251-5896**

**Disclaimer:** An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior

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questions, call:  
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