PRIOR AUTHORIZATION REQUEST
Takhzyro

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. Please complete the following questions then fax this form to the toll free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A: Please answer the following questions

1. What is the patient's diagnosis?
   - ☐ Hereditary angioedema (HAE) due to C1 inhibitor (C1-INH) deficiency [Type I or Type II], prophylaxis
   - ☐ All other indications or diagnoses - Please specify _____
2. ☐ Yes ☐ No Is the patient currently receiving Takhzyro for HAE type I or type II prophylaxis?
3. ☐ Yes ☐ No Is documentation being provided to confirm that the patient has low levels of functional C1-INH protein (less than 50% of normal) at baseline, as defined by the laboratory reference values?
4. ☐ Yes ☐ No Is documentation being provided to confirm that the patient has lower than normal serum C4 levels at baseline, as defined by the laboratory reference values?
5. ☐ Yes ☐ No Is documentation being provided to confirm the patient's HAE type I or type II diagnosis?
6. ☐ Yes ☐ No According to the prescriber, has the patient had a favorable clinical response since initiating Takhzyro prophylactic therapy compared with baseline (that is, prior to initiating prophylactic therapy)?
7. ☐ Yes ☐ No Is the requested medication being prescribed by or in consultation with an allergist/immunologist or a physician who specializes in the treatment of HAE or related disorders?
8. ☐ Yes ☐ No Will the requested medication be taken in combination with other HAE PROPHYLACTIC therapies (for example, Cinryze, Haegarda)?

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

_____

_____

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

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SECTION B Physician Signature

PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 877-251-5896

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