maryland physicians care
Medicaid with a Heart

PRIOR AUTHORIZATION REQUEST

Orladeyo

Patient Information:

Name:	
Member ID:	
Address:	
City, State, Zip:	
Date of Birth:	

Prescriber Information:

Name:	
NPI:	
Phone Number:	
Fax Number	
Address:	
City, State, Zip:	

Requested Medication

Rx Name:	
Rx Strength	
Rx Quantity:	
Rx Frequency:	
Rx Route of Administration:	
Diagnosis and ICD Code:	

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 note that supporting clinical documentation is required for **ALL** PA requests.

1	What is the patient's diagnosis? [] Hereditary angioedema (HAE) due to C1 inhibitor (C1-INH) deficiency [Type I or Type II], prophylaxis (If checked, go to 2) [] Other (If checked, no further questions)		
2	Is the patient greater than or equal to 12 year(s) of age? [If no, no further questions.]	Yes	No
3	Is the patient currently receiving Orladeyo for HAE type I or type II prophylaxis? [If yes, skip to question 6.]	Yes	No
4	Is documentation being provided to confirm that the patient has low levels of	Yes	No

If you have any questions, call:
1-888-258-8250

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	functional C1-INH protein (less than 50% of normal) at baseline, as defined by the laboratory reference values? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]		
5	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? ACTION REQUIRED: Submit supporting documentation. [If yes, skip to question 8.] [If no, no further questions.]	Yes	No
6	Is documentation being provided to confirm the patient's HAE type I or type II diagnosis? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
7	According to the prescriber, has the patient had a favorable clinical response since initiating Orladeyo prophylactic therapy compared with baseline (that is, prior to initiating prophylactic therapy)? [Note: Examples of favorable clinical response include decrease in HAE acute attack frequency, decrease in HAE attack severity, or decrease in duration of HAE attacks.] [If no, no further questions.]	Yes	No
8	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? [If no, no further questions.]	Yes	No
9	Will the requested medication be taken in combination with other HAE PROPHYLACTIC therapies (for example, Cinryze, Haegarda, Takhzyro)? [Note: Patients may use other medications, including Cinryze, for ACUTE treatment of HAE attacks, and for short- term (procedural) prophylaxis.]	Yes	No

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

SECTION B: Physician Signature

PHYSICIAN SIGNATURE DATE

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FAX COMPLETED FORM TO: 1-833-896-0656

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 authorization as per Plan policy and procedures.

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