PRIOR AUTHORIZATION REQUEST

Takhzyro

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 indication or diagnosis? [] Hereditary Angioedema (HAE) Due to C1 Inhibitor (C1-INH) Deficiency Type I (If checked, go to 2) [] Hereditary Angioedema (HAE) Due to C1 Inhibitor (C1-INH) Deficiency Type II (If checked, go to 2) [] Other (If checked, no further questions)		
2	Is the requested medication being prescribed by or in consultation with an allergist, immunologist, or a physician who specializes in the treatment of hereditary angioedema (HAE) or related disorders? [If no, no further questions.]	Yes	No

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1-888-258-8250

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3	Is the patient currently receiving the requested medication? [If no, skip to question 9.]	Yes	No
4	Has the patient been receiving medication samples for the requested medication? [If yes, skip to question 9.]	Yes	No
5	Does the patient have a previously approved prior authorization (PA) on file with the current plan? [Note: If the patient does NOT have a previously approved PA on file for the requested medication with the current plan, the renewal request will be considered under initial therapy.] [If no, skip to question 8.]	Yes	No
6	Has documentation been provided to confirm that the patient has a favorable clinical response compared to baseline since initiating prophylactic therapy with the requested medication? ACTION REQUIRED: Submit supporting documentation. [Note: Examples of favorable clinical responses include a decrease in hereditary angioedema (HAE) acute attack frequency, a decrease in HAE attack severity, or a decrease in duration of HAE attacks.] [If no, no further questions.]	Yes	No
7	Will the requested medication be used concurrently with other products indicated for prophylaxis against hereditary angioedema (HAE) attacks (for example: Cinryze, Haegarda, Orladeyo)? [No further questions.]	Yes	No
8	Has the provider documented a clinical response of the patient's condition which has stabilized or improved compared to baseline? [If no, no further questions.]	Yes	No
9	Is the patient greater than or equal to 12 year(s) of age? [If no, no further questions.]	Yes	No
10	Has documentation been provided to confirm that the patient has hereditary angioedema (HAE) due to C1 inhibitor (C1- INH) deficiency Type I or Type II by showing low levels of 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.]	Yes	No
11	Has documentation been provided to confirm that the patient has hereditary angioedema (HAE) due to C1 inhibitor (C1- INH) deficiency Type I or Type II by showing lower than normal serum C4 levels at baseline, as defined by the laboratory reference values? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No

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12	Will the requested medication be used for prophylaxis against hereditary angioedema (HAE) attacks? [If no, no further questions.]	Yes	No
13	Will the requested medication be used concurrently with other products indicated for prophylaxis against hereditary angioedema (HAE) attacks (for example: Cinryze, Haegarda, Orladeyo)? [If yes, no further questions.]	Yes	No
14	Has documentation been provided to confirm that the patient has a baseline hereditary angioedema (HAE) attack rate of greater than or equal to one attack every 4 weeks? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
15	Has it been confirmed that the patient has been evaluated for avoiding possible medication triggers for hereditary angioedema (HAE) attacks when appropriate? [NOTE: Examples of possible medication triggers include estrogen containing oral contraceptive agents, hormone replacement therapies, and antihypertensive agents containing angiotensin-converting enzyme (ACE) inhibitors and angiotensin II receptor blockers (ARBs).] [If no, no further questions.]	Yes	No
16	Have all other causes or treatable triggers of hereditary angioedema (HAE) attacks been identified and are being managed?	Yes	No

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

SECTION B: Physician Signature

PHYSICIAN SIGNATURE DATE

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.

Confidentiality: The information contained in this transmission is confidential and may be protected under the Health Insurance Portability and Accountability Act of 1996. If you are not the intended recipient any use,

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