maryland physicians care
Medicaid with a Heart

PRIOR AUTHORIZATION REQUEST

Firazyr/Sajazir/Icatibant

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 diagnosis or indication? [] Hereditary angioedema (HAE) due to C1 inhibitor (C1-INH) deficiency – treatment of acute attacks (If checked, go to 2) [] Other (If checked, no further questions)		
2	Will the requested medication be used for prophylaxis of HAE attacks? [If yes, no further questions.]	Yes	No
3	Will the requested medication be used in combination with other products indicated for the acute treatment of HAE (Berinert, Ruconest, etc)? [If yes, no further questions.]	Yes	No
4	Is the requested medication being prescribed or in consultation with an	Yes	No

PRIOR AUTHORIZATION REQUEST

	allergist/immunologist or a physician who specializes in the treatment of HAE? [If no, no further questions.]		
5	Has the patient treated previous HAE attacks with the requested medication? [If no, skip to question 10.]	Yes	No
6	Has the patient been receiving medication samples for the requested medication? [If yes, skip to question 10.]	Yes	No
7	Does the patient have a previously approved 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 9.]	Yes	No
8	Has the patient had a favorable clinical response with icatibant treatment according to the prescriber? [Note: Examples of a favorable clinical response include decrease in the duration of HAE attacks, quick onset of symptom relief, complete resolution of symptoms, or decrease in HAE acute attack frequency or severity.] [No further questions.]	Yes	No
9	Has documentation been provided to confirm that the patient has had a clinically significant response, as determined by the provider? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
10	Is the patient greater than or equal to 18 year(s) of age? [If no, no further questions.]	Yes	No
11	Has documentation been provided to confirm that the patient has normal C1q complement component level (mg/dL) on two separate instances? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
12	Has documentation been provided to confirm that the patient has serum C4 levels (mg/dL) that are below the laboratory reference range values at baseline on two separate instances? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
13	Has documentation been provided to confirm that the patient has either low C1 esterase inhibitor antigenic level (mg/dL) or low C1 esterase inhibitor functional level (percent) on two separate instances? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
14	Has documentation been provided to confirm that the patient has a history of moderate to severe cutaneous attacks OR abdominal attacks OR middle to severe airway swelling attacks of HAE? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
15	Have other causes and potentially treatable triggers of HAE attacks have been identified and optimally managed (stress, trauma, infection, etc.)? [If no, no further questions.]	Yes	No

maryland physicians care
Medicaid with a Heart

PRIOR AUTHORIZATION REQUEST

16	Have concurrent therapies that may exacerbate HAE have been evaluated and discontinued as appropriate (Estrogen containing medications, ACE-inhibitors, angiotensin II receptor blockers, etc.)?	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, distribution, or copying is strictly prohibited. If you have received this facsimile in error, please notify us immediately and destroy this document.