PRIOR AUTHORIZATION REQUEST

HAEGARDA

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. Pharmacy prior authorization reviews can be subject to trial with additional medications that are not listed within the criteria. The policies are subject to change based on COMAR requirements, MDH transmittals and updates to treatment guidelines.

1 Is the request an INITIAL or CONTINUATION of therapy?

[] Initial (If checked, go to 6)

[] Continuation (If checked, go to 2)

2 Is the patient currently receiving the requested medication? [If no, skip to question 6.] Yes No

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3	Has the patient been receiving medication samples of the requested medication? [If yes, skip to question 6.]	Yes	No
4	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 6.]	Yes	No
5	Has the patient been taking the requested medication for AT LEAST 3 months and has experienced a clinically significant benefit from the medication, as documented by the prescriber? ACTION REQUIRED: Submit supporting documentation. [Note: Examples of a favorable clinical response include decrease in Hereditary angioedema (HAE) acute attack frequency, decrease in HAE attack severity, or decrease in duration of HAE attacks.] [No further questions.]	Yes	No
6	What is the indication or diagnosis? [] Hereditary angioedema (HAE) prophylaxis due to C1 inhibitor (C1INH) deficiency (Type I or Type II) (If checked, go to 7) [] Other (If checked, no further questions)		
7	Is the patient greater than or equal to 6 year(s) of age? [If no, no further questions.]	Yes	No
8	Has documentation been submitted to confirm that the patient's Hereditary angioedema [(HAE) type I or type II] has been confirmed by low levels of functional C1 inhibitor (C1INH) 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
9	Has documentation been submitted to confirm 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? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
10	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
11	Is the requested medication being used in combination with other Hereditary angioedema (HAE) prophylactic therapies (for example, Cinryze, Takhzyro)?	Yes	No

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	[Note: Patients may use other medications, including Cinryze, for treatment of acute HAE attacks, and for short-term (procedural) prophylaxis.] [If yes, no further questions.]		
12	Does the requested dose exceed the Food and Drug Administration (FDA) approved label dosing for the indication? [Dosing: 60 units/kg every 3 or 4 days.]	Yes	No

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

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SECTION B: Physician Signature

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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.

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