PRIOR AUTHORIZATION REQUEST

ANDEMBRY

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 7) [] Continuation (If checked, go to 2)		
2	Is the patient currently receiving the requested medication? [If no, skip to question 7.]	Yes	No
3	Has the patient been receiving medication samples for the requested medication?	Yes	No

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

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	[If yes, skip to question 7.]		
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 7.]	Yes	No
5	Has the patient been established on therapy for at least 3 months? [If no, skip to question 7.]	Yes	No
6	Has documentation been submitted to confirm that the patient has had a significant response to therapy, as determined by the provider? ACTION REQUIRED: Submit supporting documentation. [Note: Example of 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
7	Is the patient greater than or equal to 12 years of age? [If no, no further questions.]	Yes	No
8	What is the indication or diagnosis? [] Hereditary angioedema (HAE) prophylaxis due to C1 inhibitor (C1NH) deficiency (If checked, go to 9) [] Other (If checked, no further questions)		
9	Has documentation been submitted to show diagnosis of hereditary angioedema (HAE) has been confirmed by lower-than-normal serum function C1-INH levels (less than 50% of normal), or 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	Has documentation been submitted to confirm other causes of angioedema have been ruled out (For example: idiopathic of acquired angioedema, angioedema associated with urticarial or hereditary angioedema type 3, angiotensin converting-enzyme induced angioedema)? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
11	Has documentation been provided to support the patient has experienced 3 or more hereditary angioedema (HAE) attacks during the 3 months prior to starting the requested medication? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No

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12	Is this 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
13	Will the requested medication be used in combination with other hereditary angioedema (HAE) prophylactic therapies (For example, Cinryve, Takhzyro, Haegarda)? [If yes, no further questions.]	Yes	No
14	Does the prescribed dosing exceed Food and Drug Administration (FDA) approved indication? Note: Dosing is Loading Dose: 400 mg SQ followed by 200 mg SQ once monthly.	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.

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