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. 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 for an INITIAL or a CONTINUATION of therapy?

[] Initial (If checked, go to 7)

[] Continuation (If checked, go to 2)

2 Is the patient currently receiving the requested medication? Yes No
[If no, skip to question 7.]

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

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3	Has the patient been receiving medication samples of the requested medication? [If yes, skip to question 7.]	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 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. [No further questions.]	Yes	No
7	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 8) [] Other (If checked, no further questions)		
8	Is the patient greater than or equal to 2 years of age? [If no, no further questions.]	Yes	No
9	Has documentation been submitted to confirm that the patient has 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
10	Has documentation been submitted 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 no, no further questions.]	Yes	No
11	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
12	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

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[If yes, no further questions.]

13	Does the requested dose exceed the Food and Drug Administration (FDA) approved label dosing for the requested indication? [Note: Dosing for Age greater than or equal to 12: 150 mg once daily, Age less than 12 - Weight 12-24 kg: 72 mg once daily, Weight 24-32 kg: 96 mg once daily, Weight 32-40 kg: 108 mg once daily, Weight greater than or equal to 40 kg: 132 mg once daily.]	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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