maryland physicians care
Medicaid with a Heart

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. 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 this request for initial therapy or for a continuation of therapy?

[] Initial (If checked, go to 8)

[] Continuation (If checked, go to 2)

2 Is the patient currently receiving the requested medication? Yes No
[If no, skip to question 8.]

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

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3	Has the patient been receiving medication samples for the requested medication? [If yes, skip to question 8.]	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 8.]	Yes	No
5	Has the patient been established on therapy for at least 3 months? [If no, skip to question 8.]	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: Examples of clinical responses include: stabilized or improved condition compared to baseline, 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	What is the diagnosis or indication? [] Hereditary Angioedema (HAE) due to C1 Inhibitor (C1-INH) Deficiency Type I (If checked, go to 9) [] Hereditary Angioedema (HAE) due to C1 Inhibitor (C1-INH) Deficiency Type II (If checked, go to 9) [] Other (If checked, no further questions)		
9	Is the patient greater than or equal to 2 years 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	Yes	No

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	laboratory reference values? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]		
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? [If no, no further questions.]	Yes	No
17	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
18	Does the requested dose exceed the FDA approved label dosing for the indication? [Note: Dosing: (12 years or older) Initial, 300 mg subQ every 2 weeks. (6-12 years of age) 150 mg subQ every 2 weeks. (2-6 years of age) 150 mg subQ every 4 weeks. Additional dosing consideration for 6 years of age and older: For 6 years or older may consider once every 4 weeks dosing when patient is attack-free for greater than 6 months.]	Yes	No

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

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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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