Member Name: {{MEMFIRST}} {{MEMLAST}} **DOB:** {{MEMBERDOB}} **PA Number:** {{PANUMBER}}

{{PANUMCODE}}

{{DISPLAY_PAGNAME}}
{{PACDESCRIPTION}}

This fax machine is located in a secure location as required by HIPAA regulations. Fax complete signed and dated forms to {{COMPANY_NAME}} at {{CLIENT_PAG_FAX}}. Please contact {{COMPANY_NAME}} at {{CLIENT_PAG_PHONE}} with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of {{DRUGNAME}}.

Patient's Name: {{MEMFIRST}} {{MEMLAST}} **Date**: {{TODAY}}
Patient's ID: {{MEMBERID}} **Patient's Date of Birth:** {{MEMBERDOB}}
Physician's Name: {{PHYFIRST}} {{PHYLAST}} **Patient Phone:** <<MEMPHONE>>
Specialty: _____ **NPI#:** _____
Physician Office Telephone: {{PHYSICIANPHONE}} **Physician Office Fax:** {{PHYSICIANFAX}}
Physician Office Address: <<PHYADDRESS1>> <<PHYADDRESS2>> <<PHYCITY>>, <<PHYSTATE>> <<PHYZIP>>
Drug Name: {{DRUGNAME}}

Quantity: _____ **Frequency:** _____ **Strength:** _____
Route of Administration: _____ **Expected Length of Therapy:** _____
Diagnosis: <<DIAGNOSIS>> **ICD Code**: <<ICD9>>

1. What is the diagnosis?
   ❑ Hereditary angioedema (HAE) with C1 inhibitor deficiency or dysfunction confirmed by laboratory testing
   ❑ Hereditary angioedema (HAE) with normal C1 inhibitor confirmed by laboratory testing
   ❑ Other _____
2. What is the ICD-10 code? _____
3. What is the patient's body weight? _____ kg or lbs ***(circle one)***
4. Is the product being requested for short-term preprocedural prophylaxis (i.e., prior to surgical or major dental procedures)? *If Yes, skip to #10* ❑ Yes ❑ No
5. Is the product being requested for the treatment of acute attacks of hereditary angioedema?
   ❑ Yes ❑ No *If No, skip to #10*
6. The preferred products for your patient's health plan are generic icatibant and Ruconest. Can the patient's treatment be switched to a preferred product?
   ❑ Yes - Please specify: _____ ❑ No - Continue request for Berinert
7. Is the product being requested for the treatment of laryngeal attacks? *If Yes, skip to #9* ❑ Yes ❑ No
8. *If the patient is 13 years of age or older,* does the patient have a documented inadequate response or intolerable adverse event to treatment with the preferred product (Ruconest)? ***ACTION REQUIRED: If Yes, attach supporting chart note(s)***. ❑ Yes ❑ No ❑ Not applicable - patient is less than 13 years of age, *skip to #10*
9. Does the patient have a documented contraindication to treatment with the preferred product (Ruconest) (i.e., a known or suspected allergy to rabbits or rabbit-derived products)? ***ACTION REQUIRED: If Yes, attach supporting chart note(s).*** ❑ Yes ❑ No
10. Will the requested drug be prescribed by or in consultation with a prescriber who specializes in the management of hereditary angioedema (HAE)? ❑ Yes ❑ No
11. What is the clinical setting in which the requested medication will be used?
    ❑ Short-term preprocedural prophylaxis (i.e., prior to surgical or major dental procedures), *skip to diagnosis section*
    ❑ Acute hereditary angioedema (HAE) attacks
    ❑ Other _____

12. Will the requested drug be used in combination with any other medication used for treatment of acute hereditary angioedema (HAE) attacks (e.g., Ruconest, Firazyr, Kalbitor)? ❑ Yes ❑ No

13. Has the patient previously received treatment with the requested medication?
❑ Yes ❑ No *If No, skip to diagnosis section.*

14. Has the patient experienced a reduction in severity and/or duration of acute attacks? ***ACTION REQUIRED: If Yes, attach supporting chart note(s) demonstrating a reduction in severity and/or duration of acute attacks.***
❑ Yes ❑ No

15. Does the patient's attack frequency, attack severity, comorbid conditions and patient's quality of life warrant prophylactic therapy? ❑ Yes ❑ No *If No, skip to diagnosis section.*

16. Has prophylactic treatment been considered? ❑ Yes ❑ No ❑ Unknown
*If No, please provide a brief rationale as to why prophylactic treatment has not been considered:*_____
_____

Complete the following section based on the patient's diagnosis, if applicable.

Section A: Hereditary Angioedema (HAE) with C1 Inhibitor Deficiency or Dysfunction Confirmed by Laboratory Testing

17. Which of the following conditions does the patient have at the time of diagnosis? ***ACTION REQUIRED: For any answer, attach laboratory test or medical record documentation confirming C1 inhibitor functional and antigenic protein levels.***
❑ A C1 inhibitor (C1-INH) antigenic level below the lower limit of normal as defined by the laboratory performing the test
❑ A normal C1-INH antigenic level and a low C1-INH functional level (functional C1-INH less than 50% or C1-INH functional level below the lower limit of normal as defined by the laboratory performing the test)
❑ Other _____

Section B: HAE with Normal C1 Inhibitor Confirmed by Laboratory Testing

18. Which of the following conditions does the patient have at the time of diagnosis? ***ACTION REQUIRED: For any answer, attach laboratory test or medical record documentation confirming normal C1 inhibitor. Based on the answer provided, attach genetic test or medical record documentation confirming F12, angiopoietin-1, plasminogen, kininogen-1 (KNG1), heparan sulfate-glucosamine 3-O-sulfotransferase 6 (HS3ST6), or myoferlin (MYOF) gene mutation testing or chart notes confirming family history of angioedema and the angioedema was refractory to a trial of high-dose antihistamine therapy.***
❑ F12, angiopoietin-1, plasminogen, kininogen-1 (KNG1), heparan sulfate-glucosamine 3-O-sulfotransferase 6 (HS3ST6), or myoferlin (MYOF) gene mutation as confirmed by genetic testing
❑ BOTH of the following: 1) Angioedema refractory to a trial of high-dose antihistamine therapy (i.e., cetirizine at 40 mg per day or the equivalent) for at least one month AND 2) Family history of angioedema
❑ Other _____

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

_____
Prescriber (Or Authorized) Signature and Date