



ANDEMBRY Federal Employee Program. PRIOR APPROVAL REQUEST

Send completed form to: Service Benefit Plan Prior Approval P.O. Box 52080 MC 139 Phoenix, AZ 85072-2080 Attn: Clinical Services Fax: 1-877-378-4727

Additional information is required to process your claim for prescription drugs. Please complete the cardholder portion, and have the prescribing physician complete the physician portion and submit this completed form.

Form with sections: Patient Information (required), Provider Information (required), and PHYSICIAN COMPLETES. Includes fields for Date, Patient Name, Date of Birth, Sex, Street Address, City, State, Zip, Patient ID, Provider Name, Specialty, NPI, Office Phone, Office Fax, Office Street Address, City, State, Zip, and Physician Signature.

Andembry (garadacimab-gxii)

\*\*Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit

NOTE: Form must be completed in its entirety for processing

Is this request for brand or generic? Brand Generic

- 1. Does the patient have a diagnosis of hereditary angioedema (HAE)? Yes No
2. Is Andembry being used to treat acute attacks or for the routine prevention of angioedema attacks? Please select answer below: Acute attacks Routine prevention
3. Will this medication be used in combination with another agent for the prevention of hereditary angioedema attacks (e.g., Cinryze, Haegarda, Orladeyo, Takhzyro)? Yes\* No
4. Has the patient been on Andembry continuously for the last 6 months, excluding samples? Please select answer below: NO - this is INITIATION of therapy, please answer the following questions: a. Does the patient have a normal C1 inhibitor as confirmed by laboratory testing? Select answer below: Yes: Please answer the following questions: i. Does the patient have a F12, angiotensin-converting enzyme, or kininogen-1 (KNG1) gene mutation as confirmed by genetic testing? Yes No ii. Does the patient have a documented family history of angioedema? Yes\* No \*If YES, is the angioedema refractory to a trial of high-dose antihistamine such as cetirizine for at least one month? Yes No No: Please answer the following questions: i. Does the patient have a C1 inhibitor deficiency or dysfunction as confirmed by laboratory testing? Yes No ii. Is the patient's C4 level below the lower limit of normal as defined by the laboratory performing the test? Yes No iii. Does the patient have a normal C1-INH antigenic level as defined by the laboratory performing the test? Yes: Does the patient have a C1-INH functional level less than 50% or a C1-INH functional level below the lower limit of normal as defined by the laboratory performing the test? Yes No No: Is the patient's C1 inhibitor (C1-INH) antigenic level below the lower limit of normal as defined by the laboratory performing the test? Yes No YES - this is a PA renewal for CONTINUATION of therapy, please answer the following question: a. Has the patient experienced a significant reduction in frequency of hereditary angioedema attacks since starting treatment? Yes No