BlueCross BlueShield Federal Employee Program

DAWNZERA
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.

Patient Information (required)			**Provider Information (required)**		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: R			Physician Signature:		
PHYSICIAN COMPLETES					

Dawnzera (donidalorsen)

****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

Will the patient need more than 3 autoinjectors every 84 days? ❑Yes* ❑No
If YES, please specify the requested quantity: _____ autoinjectors every 84 days

1. Does the patient have a diagnosis of hereditary angioedema (HAE)? ❑Yes ❑No
2. Is Dawnzera 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
   If YES, specify the medication(s): _____
4. Has the patient been on Dawnzera 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, angiopoietin-1, plasminogen, 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