EKTERLY 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 patient 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

Ekterly

(sebetralstat)

****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. What is the patient's diagnosis?
   ❑Hereditary angioedema (HAE)
   ❑Other diagnosis ***(please specify)***: ______________________________

2. Is this medication being used to treat acute attacks or for the routine prevention of hereditary angioedema (HAE)? ***Please select answer:*** ❑Acute attacks **OR** ❑Routine prevention

3. Will this medication be used in combination with another agent for treating acute attacks of hereditary angioedema (HAE) (e.g., Berinert, Firazyr/Sajazir, Kalbitor, Ruconest)? ❑Yes* ❑No
   ****If YES***, specify the medication(s): ______________________________

4. Has the patient been on this medication 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? ***Please 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 C1inhibitor 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? ***Please select answer below:***
   ❑**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 reduction in severity and/or duration of hereditary angioedema attacks? ❑Yes ❑No

The information provided on this form will be used to determine the provision of healthcare benefits under a U.S. federal government program, and any falsification of records may subject the provider to prosecution, either civilly or criminally, under the False Claim Acts, the False Statements Act, the mail or wire fraud statutes, or other federal or state laws prohibiting such falsification. **Prescriber Certification:** I certify all information provided on this form to be true and correct to the best of my knowledge and belief. I understand that the insurer may request a medical record if the information provided herein is not sufficient to make a benefit determination or requires clarification and I agree to provide any such information to the insurer.