BlueCross BlueShield Federal Employee Program

TAKHZYRO
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					

Takhzyro (lanadelumab-flyo)

****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 Takhzyro being used to treat acute attacks or for the routine prevention of angioedema attacks? ***Please select answer below:***
   ❑Acute attacks ❑Routine prevention
3. Will the patient also be using another agent for the prevention of hereditary angioedema attacks (e.g., Cinryze, Haegarda, Orladeyo)? ❑Yes* ❑No
   ****If YES***, specify the medication: _____
4. Has the patient been on Takhzyro 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

b. Has the patient had an inadequate treatment response or have an intolerance to a short-term course (5 days or less) of an androgen such as danazol? ❑Yes ❑No

c. Does the patient have one of the following that would be a contraindication to an androgen such as danazol? ***Answer below:***

❑Active thrombosis or history of thromboembolic disease ❑Androgen-dependent tumor ❑Breast feeding
❑Markedly impaired hepatic, renal or cardiac function ❑Porphyria ❑Prepubertal child
❑Pregnancy (member is currently pregnant or may become pregnant) ❑Undiagnosed abnormal genital bleeding
❑Other reason ***(please specify)***: _____
❑None of the above

❑**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

BlueCross BlueShield
Federal Employee Program

TAKHZYRO
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

Message:

Attached is a Prior Authorization request form.

For your convenience, there are 3 ways to complete a Prior Authorization request:

Electronically Online (ePA) Results in 2-3 **minutes** **FASTEST AND EASIEST**	Now you can get responses to drug Prior Authorization requests **securely** online. **Online** submissions may receive **instant** responses and do not require faxing or phone calls. Requests can be made 24 hours a day, 7 days a week. For more information on electronic prior authorization (ePA) and to register, go to **Caremark.com/ePA.**
Phone (4-5 **minutes** for response)	The FEP Clinical Call Center can be reached at **(877)-727-3784** between the hours of 7AM-9PM Eastern Time. A live representative will assist with the Prior Authorization, asking for the same information contained on the attached form. Please review the form and have your answers ready for faster service. The process over the phone takes on average between 4 and 5 minutes.
Fax (3-5 **days** for response)	Fax the attached form to **(877)-378-4727**. Requests sent via fax will be processed and responded to within 5 business days. The form must be filled out completely, if there is any missing information the Prior Authorization request cannot be processed. ***Please only fax the completed form once as duplicate submissions may delay processing times.***