PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Haegarda

Phone: 800-728-7947 Fax back to: 866-880-4532

The Scott & White Health Plan Pharmacy Department manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

Patient Name:	**Prescriber Name:** **Supervising Physician:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

Q1. What diagnosis is this drug being prescribed for?

- ☐ Hereditary angioedema (HAE)
- ☐ Other (please specify)

Q2. Please provide ICD code(s) for diagnosis.

Q3. Which type of request is this?

- ☐ Initial
- ☐ Continuation (please provide start date)

Q4. For INITIAL REQUEST, please provide clinical documentation of diagnosis, chart notes, labs, anticipated attack frequency, and any additional documentation that may be beneficial to pharmacist and medical director during the prior authorization case review.

Q5. For CONTINUATION, please supply clinical documentation of documented patient response and ability to tolerate medication.

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Patient Name:	**Prescriber Name:** **Supervising Physician:**

Q6. Please select the prescriber's specialty.

- ☐ Allergist
- ☐ Immunology Specialist
- ☐ Hematologist
- ☐ Other (Please Specify)

Q7. Please indicate location of administration.

- ☐ Home
- ☐ Physician office (drug from office stock - buy and bill)
- ☐ Physician office (MEMBER to obtain drug from PHARMACY with a prescription)
- ☐ Other

Q8. Is the patient using this for PROPHYLAXIS of acute HAE attacks?

- ☐ Yes
- ☐ No (Please use form for HAE treatment drugs)

Q9. Does the patient have any of the following? Must be confirmed through chart notes.

- ☐ Two or more attacks per month requiring therapy
- ☐ Disabling symptoms 5 or more days per month
- ☐ Laryngeal edema
- ☐ Scheduled major dental work or surgical procedure requiring short term prophylaxis (please provide procedure period)

Q10. Does the patient have failure or, intolerance to, or contraindication to any of the following? If yes, please specify.

- ☐ Attenuated androgens (ex. danazol, stanozolol)
- ☐ Antifibrinolytics (ex. aminocaproic acid)
- ☐ Other (please specify)

Q11. Does the patient have a contraindication to therapy?

☐ Yes ☐ No

Q12. Is the patient using any medications know to cause angioedema (i.e. ACE inhibitor, ARB, or estrogen)?

☐ Yes (please explain) ☐ No

Q13. If request is for CONTINUATION, has the patient shown improvement with any of the following?

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Patient Name:	**Prescriber Name:** **Supervising Physician:**

- ☐ Approaching 2 or fewer acute HAE attacks per month while on prophylaxis
- ☐ A decrease in quantity, severity, and length of HAE attacks
- ☐ Other (please specify)

Q14. Additional Comments

Prescriber Signature

Date

□ Expedited/Urgent - By checking this box and signing above, I certify that applying the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function

Lack of the necessary documentation may result in a medical necessity denial. Requesting providers may speak to the SWHP medical director at 1-888-316-7947 regarding the case to have an opportunity to help impact the decision on a request before coverage has been decided.