PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Hereditary Angioedema Treatment Therapies

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 drug is being requested?

- ☐ Berinert
- ☐ Firazyr
- ☐ Kalbitor
- ☐ Ruconest

Q2. What are the quantity and days supply requested?

Q3. What diagnosis is this drug being prescribed for?

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

Q4. Please provide ICD code(s) for diagnosis.

Q5. Which type of request is this?

☐ Initial ☐ Continuation (please provide start date)

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Q6. 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.

Q7. For CONTINUATION, please supply clinical documentation of acute HAE attack(s) requiring treatment including date of attack and number of doses utilized.

Q8. Please select the prescriber's specialty.

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

Q9. Will the quantity being requested result in a supply on hand of more than two doses?

☐ Yes (please provide chart notes confirming anticipated attack frequency requiring treatment) ☐ No

Q10. Is the patient using this for TREATMENT of acute HAE attacks?

☐ Yes ☐ No (Please use form for Cinryze or Haegarda)

Q11. If request is for RUCONEST, will the patient be using it for laryngeal attacks?

- ☐ Yes
- ☐ No
- ☐ N/A (request is not for Ruconest)

Q12. Does the patient have a contraindication to therapy?

☐ Yes ☐ No

Q13. Is the patient using any medications know to cause angioedema (i.e. ACE inhibitor, ARB, or estrogen)?

☐ Yes (please explain) ☐ No

Q14. Will the requested drug be the only medication prescribed for treatment of acute attacks?

☐ Yes ☐ No

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Q15. Does the patient have failure or, intolerance to, or contraindication to any of the following?

- ☐ Berinert
- ☐ Firazyr
- ☐ Kalbitor
- ☐ Ruconest

Q16. Who is the ENTITY that will be submitting the CLAIM for the DRUG and seeking reimbursement?

- ☐ Pharmacy
- ☐ Individual prescriber
- ☐ Provider or specialty group
- ☐ Facility
- ☐ Other (please specify)

Q17. Provide name and NPI of the billing entity

Q18. Will the claim for the drug be submitted as a MEDICAL claim or PHARMACY claim (Note: If a pharmacy will be submitting a MEDICAL claim for drug reimbursement, answer MEDICAL)?

☐ Medical ☐ Pharmacy

Q19. Additional Comments

Prescriber Signature

Date

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

□ 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 a SWHP pharmacist or medical director at 1-800-728-7947 regarding the case to have an opportunity to help impact the decision on a request before coverage has been decided.