Haegarda (C1 esterase inhibitor)
Prior Authorization Request Form

Caterpillar Prescription Drug Benefit
Phone: 877-228-7909 Fax: 800-424-7640

Instructions: Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the authorization request). Information contained in this form is Protected Health Information under HIPAA.

☐ **URGENT**

MEMBER INFORMATION	
LAST NAME:	**FIRST NAME:**
PHONE NUMBER:	**DATE OF BIRTH:**
STREET ADDRESS:	
CITY:	**STATE:** **ZIP CODE:**
PATIENT INSURANCE ID NUMBER:	

☐ **MALE** ☐ **FEMALE** **HEIGHT (IN/CM):** _____ **WEIGHT (LB/KG):** _____ **ALLERGIES:** _____

IF YOU ARE NOT THE PATIENT OR THE PRESCRIBER, YOU WILL NEED TO SUBMIT A PHI DISCLOSURE AUTHORIZATION FORM WITH THIS REQUEST WHICH CAN BE FOUND AT THE FOLLOWING LINK: HTTPS://MAGELLANRX.COM/MEMBER/EXTERNAL/COMMERCIAL/COMMON/DOC/EN-US/PHI_DISCLOSURE_AUTHORIZATION.PDF

PATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE): _____
AUTHORIZED REPRESENTATIVE'S PHONE NUMBER: _____

PRESCRIBER INFORMATION	
LAST NAME:	**FIRST NAME:**
PRESCRIBER SPECIALTY:	**EMAIL ADDRESS:**
NPI NUMBER:	**DEA NUMBER:**
PHONE NUMBER:	**FAX NUMBER:**
STREET ADDRESS:	
CITY:	**STATE:** **ZIP CODE:**
REQUESTOR (if different than prescriber)**:**	**OFFICE CONTACT PERSON:**

MEDICATION OR MEDICAL DISPENSING INFORMATION			
MEDICATION NAME:			
DOSE/STRENGTH:	**FREQUENCY:**	**LENGTH OF THERAPY/REFILLS:**	**QUANTITY:**
☐ **NEW THERAPY** ☐ **RENEWAL** DURATION OF THERAPY (SPECIFIC DATES):		**IF RENEWAL:** DATE THERAPY INITIATED:	

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MEMBER'S LAST NAME: _____ **MEMBER'S FIRST NAME:** _____

1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION? ☐ YES (if yes, complete below) ☐ NO		
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE)**:**	**DURATION OF THERAPY** (SPECIFY DATES)**:**	**RESPONSE/REASON FOR FAILURE/ALLERGY:**

2. LIST DIAGNOSES:	**ICD-10:**
☐ Hereditary Angioedema (HAE) ☐ Other diagnosis: _____ICD-10_____	

3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.

Clinical Information:

Is this drug being prescribed to this patient as part of a treatment regimen specified within a sponsored clinical trial? ☐ Yes ☐ No

Has patient had four or more hereditary angioedema attacks over a 2-month consecutive period that required acute treatment, medical attention or caused significant functional impairment? ☐ Yes ☐ No

Is patient's functional C1-inhibitor level less than 50%? ☐ Yes ☐ No *(Copy of lab report must be submitted.)*

Is patient's C4 antigen level below the laboratory's listed reference range? ☐ Yes ☐ No *(Copy of lab report must be submitted.)*

Has patient had an inadequate response with attenuated androgens(such as danazol)? ☐ Yes ☐ No

Does patient have at least one (1) contraindication to the use of attenuated androgens (such as danazol)?
☐ Yes ☐ No

<u>Please select one:</u>

- ☐ **Hypersensitivity to the androgen or any component of the formulation**
- ☐ **Undiagnosed genital bleeding**
- ☐ **Pregnancy**
- ☐ **Breastfeeding**
- ☐ **Porphyria**
- ☐ **Impaired hepatic function**
- ☐ **Impaired renal function**
- ☐ **Impaired cardiac function**

Is patient going to be using any other HAE prophylactic agent such as Takhzyro (lanadelumab-flyo), Cinryze (C1 esterase inhibitor), or Orladeyo (berotralstat) in combination with Haegarda? ☐ Yes ☐ No

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

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MEMBER'S LAST NAME: _____ **MEMBER'S FIRST NAME:** _____

Please note: Not all drugs/diagnosis are covered on all plans. This request may be denied unless all required information is received.

ATTESTATION: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature or Electronic I.D. Verification: _____ **Date:** _____

FAX THIS FORM TO: 800-424-7640
MAIL REQUESTS TO: Magellan Rx Management Prior Authorization Program
Attn: CP - 4201
P.O. Box 64811
St. Paul, MN 55164-0811