

Firazyr (icatibant) 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.

			URGEN	
MEMBER INFORMATION				
LAST NAME:		FIRST NAME:		
PHONE NUMBER:		DATE OF BIRTH:		
STREET ADDRESS:				
CITY:		STATE: ZIP CO	DDE:	
PATIENT INSURANCE ID	NUMBER:			
MALE FEMALE	HEIGHT (IN/CM): W	EIGHT (LB/KG): ALLE	ERGIES:	
		DISCLOSURE AUTHORIZATION FORM WITH THI OMMON/DOC/EN-US/PHI_DISCLOSURE_AUTH		
		BLE):		
PRESCRIBER INFORMATI	ON			
LAST NAME:		FIRST NAME:	FIRST NAME:	
PRESCRIBER SPECIALTY:		EMAIL ADDRESS:	EMAIL ADDRESS:	
NPI NUMBER:		DEA NUMBER:	DEA NUMBER:	
PHONE NUMBER:		FAX NUMBER:	FAX NUMBER:	
STREET ADDRESS:				
CITY:		STATE: ZIP CO	DDE:	
REQUESTOR (if different than prescriber):		OFFICE CONTACT PERSO	OFFICE CONTACT PERSON:	
		1		
MEDICATION OR MEDIC	AL DISPENSING INFORMATIO	N		
MEDICATION NAME:				
DOSE/STRENGTH:	FREQUENCY:	LENGTH OF THERAPY/REFILLS:	QUANTITY:	
NEW THERAPY RENEWAL DURATION OF THERAPY (SPECIFIC DATES):		IF RENEWAL: DATE THER	IF RENEWAL: DATE THERAPY INITIATED:	
Continued on next page.				

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MEMBER'S LAST NAME:	MEMBER'S FIRST NAME:			
1. HAS THE PATIENT TRIED ANY OTHE	R 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)		165 10.		
□ Other diagnosis:ICD-	10			
3. REQUIRED CLINICAL INFORMATION PRIOR AUTHORIZATION.	: PLEASE PROVIDE ALL RELEVANT CLINIC	AL INFORMATION TO SUPPORT A		
For Initial Request:				
Is the prescriber an allergist or immun	ologist? Yes No			
Does the patient's lab report show servalues? ☐ Yes ☐ No Please provide laboratory report.	rum C4 and functional C1-inhibitor leve	ls lower than normal		
Does the patient have a history of at least one moderate to severe attack of HAE and/or has the patient experienced a laryngeal attack (airway obstruction)? ☐ Yes ☐ No Please provide documentation.				
Has the patient experienced a laryngeal attack (airway obstruction)? ☐ Yes ☐ No				
Is this being used for acute treatment	only? □ Yes □ No			
Reauthorization:				
positive clinical response? Yes No	escribing the patient's positive clinical r			
Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?				
information is received.	e covered on all plans. This request may	·		
the Health Plan, insurer, Medical Grou	n provided is true and accurate to the be p or its designees may perform a routine pursey of the information reported on the	audit and request the medical		

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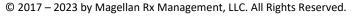
Prescriber Signature or Electronic I.D. Verification:	Date	·
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CONFIDENTIALITY NOTICE: The documents accompanying this transmission contain confidential health information that is legally privileged. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately (via return FAX) and arrange for the return or destruction of these documents.

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



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