



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](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:
<input type="checkbox"/> NEW THERAPY	<input type="checkbox"/> RENEWAL	IF RENEWAL: DATE THERAPY INITIATED:	
DURATION OF THERAPY (SPECIFIC DATES):			

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

1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION? <input type="checkbox"/> YES (if yes, complete below) <input type="checkbox"/> NO		
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE): 	DURATION OF THERAPY (SPECIFY DATES): 	RESPONSE/REASON FOR FAILURE/ALLERGY:
2. LIST DIAGNOSES: <input type="checkbox"/> Hereditary Angioedema (HAE) <input type="checkbox"/> Other diagnosis: _____ ICD-10 _____		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? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No Is patient's functional C1-inhibitor level less than 50%? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(Copy of lab report must be submitted.)</i> Is patient's C4 antigen level below the laboratory's listed reference range? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(Copy of lab report must be submitted.)</i> Has patient had an inadequate response with attenuated androgens (such as danazol)? <input type="checkbox"/> Yes <input type="checkbox"/> No Does patient have at least one (1) contraindication to the use of attenuated androgens (such as danazol)? <input type="checkbox"/> Yes <input type="checkbox"/> No Please select one: <input type="checkbox"/> Hypersensitivity to the androgen or any component of the formulation <input type="checkbox"/> Undiagnosed genital bleeding <input type="checkbox"/> Pregnancy <input type="checkbox"/> Breastfeeding <input type="checkbox"/> Porphyria <input type="checkbox"/> Impaired hepatic function <input type="checkbox"/> Impaired renal function <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <hr/>		





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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:** _____

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; c/o Magellan Health, Inc.
4801 E. Washington Street, Phoenix, AZ 85034
Phone: 877-228-7909

