

Please complete this entire form and fax it to: **866-940-7328**. If you have questions, please call **800-310-6826**.
This form contains multiple pages. Please complete all pages to avoid a delay in our decision.
Allow at least 24 hours for review.

Section A – Member Information

First Name:	Last Name:	Member ID:
Address:		
City:	State:	ZIP Code:
Phone:	DOB:	Allergies:
Primary Insurance Information:		

Is the requested medication **New** or **Continuation of Therapy?** If continuation, list start date: _____
Is this patient currently hospitalized? **Yes** **No** If recently discharged, list discharge date: _____

Section B - Provider Information

First Name:	Last Name:			M.D./D.O.
Address:		City:	State:	ZIP code:
Phone:	Fax:	NPI #:	Specialty:	
Office Contact Name / Fax attention to:				

Section C - Medical Information

Medication:	Strength:
Directions for use:	Quantity:
Diagnosis (Please be specific & provide as much information as possible):	ICD-10 CODE:
Is this member pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what is this member's due date? _____	

Section D – Previous Medication Trials

Medications	Strength	Directions	Dates of Therapy	Reason for failure / discontinuation

Section E – Additional information and Explanation of why preferred medications would not meet the patient's needs:
Please refer to the patient's PDL for a list of preferred alternatives

Member First name:	Member Last name:	Member DOB:
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Clinical and Drug Specific Information

ALL REQUESTS

<input type="checkbox"/> Yes <input type="checkbox"/> No	<p>Does the patient have a diagnosis of hereditary angioedema (HAE) as confirmed by one of the following? <i>(If yes, check which applies)</i></p> <ul style="list-style-type: none"> <input type="checkbox"/> Confirmed monoallelic mutation known to cause HAE in either the SERPING1 or F12 gene <input type="checkbox"/> A C4 level below the lower limit of normal and one of the following (per laboratory standard): C1 inhibitor (C1-INH) antigenic level below the lower limit of normal OR C1-INH functional level below the lower limit of normal
<input type="checkbox"/> Yes <input type="checkbox"/> No	<p>Will Haegarda be used for prophylaxis against HAE attacks?</p>
<input type="checkbox"/> Yes <input type="checkbox"/> No	<p>Will Haegarda be used in combination with other approved C1 esterase inhibitors indicated for prophylaxis against HAE attacks (e.g. Cinryze)?</p> <p><i>If yes, list medication and rationale:</i></p>
<input type="checkbox"/> Yes <input type="checkbox"/> No	<p>Does the prescriber attest that patient has experienced attacks of a severity and/or frequency such that they would clinically benefit from prophylactic therapy with Haegarda?</p>
<input type="checkbox"/> Yes <input type="checkbox"/> No	<p>Is Haegarda prescribed by one of the following? <i>(If yes, check which applies)</i></p> <ul style="list-style-type: none"> <input type="checkbox"/> Immunologist <input type="checkbox"/> Allergist <input type="checkbox"/> Rheumatologist

Physician Signature: _____ **Date:** _____

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