PRIORITY PARTNERS
7231 Parkway Dr., Suite 100
Hanover, MD 21076

JOHNS HOPKINS
HEALTH PLANS

4/2/2026

Prior Authorization

Internal Use Only

JOHNS HOPKINS HEALTH PLANS

Dawnzera - Priority Partners MCO

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Johns Hopkins Health Plans at **1-410-424-4607**.
Please contact Johns Hopkins Health Plans at **1-888-819-1043** with questions regarding the Prior Authorization process.
When conditions are met, we will authorize the coverage of Dawnzera - Priority Partners MCO.

Drug Name (select from list of drugs shown)
Dawnzera (donidalorsen)

Quantity Frequency Strength

Route of Administration Expected Length of Therapy

Patient Information
Patient Name: _____
Patient ID: _____
Patient Group No.: _____
Patient DOB: _____
Patient Phone:

Prescribing Physician
Physician Name: _____
Physician Phone: _____
Physician Fax: _____
Physician Address: _____
City, State, Zip: _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

Please circle the appropriate answer for each question.

1. Is the patient less than 12 years of age? Y N

[If yes, no further questions.]

2. Will the requested medication be used for the treatment of acute hereditary angioedema (HAE) attacks? Y N

	[If yes, no further questions.]	
3.	Does the patient a history of a hypersensitivity reaction to atrasentan or any component of the requested medication?	Y N
	[If yes, no further questions.]	
4.	Will the requested medication be used concurrently with other hereditary angioedema (HAE) prophylactic therapies (e.g., Andembry, Cinryze, Haegarda, Orladeyo, Takhzyro, etc.)?	Y N
	[If yes, no further questions.]	
5.	Will the requested medication be used for any indications that are not Food and Drug Administration (FDA)-approved or guideline-supported?	Y N
	[If yes, no further questions.]	
6.	Has the plan authorized this medication in the past for this patient (i.e., previous authorization is on file under this plan)?	Y N
	NOTE: The use of physician samples, or manufacturer product discounts, does not guarantee coverage under the provisions of the medical and/or pharmacy benefit. All pertinent criteria must be met in order to be eligible for benefit coverage.	
	[If no, skip to question 11.]	
7.	Has the patient had a beneficial response to treatment?	Y N
	NOTE: Submission of medical records is required.	
	[If no, no further questions.]	
8.	Has the patient experienced a significant reduction in frequency of attacks (e.g., greater than or equal to 50%) since starting prophylactic treatment?	Y N
	NOTE: Submission of medical records is required.	
	[If no, no further questions.]	
9.	Has the patient reduced the use of medications to treat acute attacks since starting prophylactic treatment?	Y N
	NOTE: Submission of medical records is required.	
	[If no, no further questions.]	
10.	Is the requested medication being dosed every 8 weeks or dosing every 8 weeks has been considered if the patient is well-controlled on therapy?	Y N
	NOTE: Submission of medical records is required.	
	[No further questions.]	
11.	Is the requested medication being used for the prevention of hereditary angioedema (HAE) attacks?	Y N
	NOTE: Submission of medical records is required.	
	[If no, no further questions.]	
12.	Does the patient have a C1 inhibitor deficiency or dysfunction as confirmed by laboratory testing?	Y N

NOTE: Submission of medical records is required.		
[If no, skip to question 15.]		
13. Does the patient have a C1 inhibitor (C1-INH) antigenic level below the lower limit of normal?	Y N	
NOTE: Submission of medical records is required.		
[If yes, skip to question 18.]		
14. Does the patient have a normal C1 inhibitor (C1-INH) antigenic level and a low C1-INH functional level (functional C1- INH less than 50% or C1-INH functional level below the lower limit of normal)?	Y N	
NOTE: Submission of medical records is required.		
[If yes, skip to question 18.]		
[If no, no further questions.]		
15. Does the patient have normal C1 inhibitor (C1-INH) as confirmed by laboratory testing?	Y N	
NOTE: Submission of medical records is required.		
[If no, no further questions.]		
16. Does the patient have an F12, angiopoietin-1, plasminogen, kininogen-1 (KNG1), heparan sulfate-glucosamine 3-O-sulfotransferase 6 (HS3ST6), or myoferlin (MYOF) pathogenic variant as confirmed by genetic testing?	Y N	
NOTE: Submission of medical records is required.		
[If yes, skip to question 18.]		
17. Does the patient have a family history of angioedema and the patient's angioedema was refractory to a trial of high-dose antihistamine therapy (i.e., cetirizine at 40 mg per day or the equivalent) for at least one month?	Y N	
NOTE: Submission of medical records is required.		
[If no, no further questions.]		
18. Have other causes of angioedema been ruled out (e.g., angiotensin-converting enzyme inhibitor [ACE-I] induced angioedema, angioedema related to an estrogen-containing drug, allergic angioedema)?	Y N	
NOTE: Submission of medical records is required.		

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

Prescriber (Or Authorized) Signature and Date