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

4/2/2026

Prior Authorization

Internal Use Only

JOHNS HOPKINS HEALTH PLANS

Orladeyo - 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 Orladeyo - Priority Partners MCO.

Drug Name (select from list of drugs shown)
Orladeyo (berotralstat)

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 2 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

Question	Response	
[If yes, no further questions.]		
3. Will the requested medication be used concurrently with other hereditary angioedema (HAE) prophylactic therapies (e.g., Andembry, Cinryze, Haegarda, Takhzyro, Dawnzera etc.)?	Y N	
[If yes, no further questions.]		
4. 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.]		
5. 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 8.]		
6. Has the patient experienced a significant reduction in frequency of attacks (e.g. greater than or equal to 50%) since starting treatment?	Y N	______
NOTE: Submission of medical records is required.		
[If no, no further questions.]		
7. Has the patient reduced the use of medications to treat acute attacks?	Y N	______
NOTE: Submission of medical records is required.		
[No further questions.]		
8. Is the requested medication being used for hereditary angioedema (HAE) prophylaxis?	Y N	______
NOTE: Submission of medical records is required.		
[If no, no further questions.]		
9. Does the patient have C1 inhibitor deficiency or dysfunction as confirmed by laboratory testing?	Y N	______
NOTE: Submission of medical records is required.		
[If no, skip to question 13.]		
10. Does the patient have a C4 level below the lower limit of normal as defined by the laboratory test?	Y N	______
NOTE: Submission of medical records is required.		
[If no, no further questions.]		
11. Does the patient have C1 inhibitor (C1-INH) antigenic level below the lower limit of normal supported by laboratory test?	Y N	______
NOTE: Submission of medical records is required.		
[If yes, no further questions.]		
12. Does the patient have normal C1 inhibitor (C1-INH) antigenic level and a low C1-INH functional level	Y N	______

(functional C1-INH less than 50% or C1-INH functional level below the lower limit of normal supported by laboratory test)?		
NOTE: Submission of medical records is required.		
[No further questions.]		
13. Does the patient have normal C1 inhibitor as confirmed by laboratory testing?	Y N	
NOTE: Submission of medical records is required.		
[If no, no further questions.]		
14. Does the patient have an F12, angiopoietin-1, plasminogen, kininogen-1 (KNG1), heparan sulfate-glucosamine 3-O-sulfotransferase 6 (HS3ST6), or myoferlin (MYOF) gene mutation as confirmed by genetic testing?	Y N	
NOTE: Submission of medical records is required.		
[If yes, no further questions.]		
15. Does the patient have a family history of angioedema and the 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.		

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