

TRICARE Prior Authorization Request Form for
donidalorsen (Dawnzera)



7231 Parkway Drive, Suite 100
Hanover, MD 21076

**Fax completed form and
applicable progress notes to:
(410) 424-4037**

USFHP Pharmacy Prior Authorization Form

To be completed by requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

Prior authorization does not expire.

Step 1 Please complete patient and physician information (please print):

Patient Name:	Physician Name:
Address:	Address:
Sponsor ID #	Phone #:
Date of Birth:	Secure Fax #:

Step 2 Please complete the clinical assessment:

1. Is the patient 12 years of age or older?	☐ Yes Proceed to Question 2	☐ No STOP Coverage not approved
2. What is the indication or diagnosis?	☐ Hereditary angioedema (HAE) – Proceed to question 3 ☐ Other – STOP – Coverage not approved	
3. Is the requested medication being prescribed for prophylaxis to prevent attacks of hereditary angioedema (HAE)?	☐ Yes Proceed to Question 4	☐ No STOP Coverage not approved
4. Is the requested medication being prescribed by an allergist, immunologist, or rheumatologist, or HAE specialist?	☐ Yes Proceed to Question 5	☐ No STOP Coverage not approved
5. Does the patient have monthly HAE attacks or a history of severe attacks that require prophylaxis treatment (that is, 2 HAE attacks/month OR MORE, laryngeal attacks, etc.)?	☐ Yes Proceed to Question 6	☐ No STOP Coverage not approved
6. Is the patient currently receiving another drug for HAE prophylaxis (for example, Orladeyo, Takhzyro, Cinryze or Haegarda will not be used concomitantly)?	☐ Yes STOP Coverage not approved	☐ No Proceed to Question 7
7. Has the patient had an inadequate response to all of the following: (1) One C1-inhibitor AND (2) One Kallikrein inhibitor?	☐ Yes Sign and date below	☐ No Proceed to Question 8

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8. Has the patient had an adverse reaction to all of the following: (1) One C1-inhibitor AND (2) One Kallikrein inhibitor?	☐ Yes Sign and date below	☐ No Proceed to Question 9
9. Does the patient have a contraindication to all of the following: (1) One C1-inhibitor AND (2) One Kallikrein inhibitor?	☐ Yes Sign and date below	☐ No STOP Coverage not approved

Step I certify the above is true to the best of my knowledge. Please sign and date:

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Prescriber Signature

Date

[11 September 2025]

For Internal Use Only

☐ Approved:	Duration of Approval: ____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: