Prior Authorization Request Form for HAE Agents: Cinryze, Haegarda

JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE
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.

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. Which medication is being requested?	☐ **Cinryze** **Proceed to question 2**	☐ **Haegarda** **Proceed to question 3**
2. Is the patient GREATER THAN or EQUAL TO 13 years of age?	☐ **Yes** **Proceed to question 4**	☐ **No** **STOP** **Coverage not approved**
3. Is the patient GREATER THAN or EQUAL TO 12 years of age?	☐ **Yes** **Proceed to question 4**	☐ **No** **STOP** **Coverage not approved**
4. Does the patient have a diagnosis of hereditary angioedema (HAE) Type I, II, or III (HAE with normal C1-esterase inhibitor)?	☐ **Yes** **Proceed to question 5**	☐ **No** **STOP** **Coverage not approved**
5. Is the requested medication being prescribed by an allergist, immunologist, or rheumatologist, or in consultation with an HAE specialist?	☐ **Yes** **Proceed to question 6**	☐ **No** **STOP** **Coverage not approved**
6. Does the patient experience GREATER THAN or EQUAL to two hereditary angioedema (HAE) attacks per month?	☐ **Yes** **Proceed to question 7**	☐ **No** **STOP** **Coverage not approved**
7. Is the patient on two prophylaxis C-1 inhibitor agents concomitantly (such as Haegarda and Cinryze)?	☐ **Yes** **STOP** **Coverage not approved**	☐ **No** **Proceed to question 8**

Continue on next page

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8. Has the patient tried and failed an attenuated androgen (danazol)?	☐ **Yes** **Sign and date below**	☐ **No** **Proceed to question 9**
9. Has the patient experienced, or is expected to experience, serious adverse effects from the use of an androgen (for example: virilization of women, stroke, or myocardial infarction, venous thromboembolism)?	☐ **Yes** **Sign and date below**	☐ **No** **Proceed to question 10**
10. Is the patient a female of childbearing age?	☐ **Yes** **Sign and date below**	☐ **No** **STOP** **Coverage not approved**

Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date.

_____ _____

Prescriber Signature Date

[22 November 2017]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: