TRICARE Prior Authorization Request Form for
lanadelumab **(Takhzyro),** berotralstat hydrochloride **(Orladeyo)**

JOHNS HOPKINS
HEALTH PLANS
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 2 years of age or older?	☐ Yes Proceed to question **2**	☐ No **STOP** Coverage not approved
2. Does the patient have a diagnosis of hereditary angioedema (HAE)?	☐ Yes Proceed to question **3**	☐ No **STOP** Coverage not approved
3. Is the requested medication being prescribed by an allergist, immunologist, or rheumatologist, or in consultation with an HAE specialist?	☐ Yes Proceed to question **4**	☐ No **STOP** Coverage not approved
4. Does the patient have monthly HAE attacks or a history of severe attacks that require prophylaxis treatment (for example, GREATER THAN OR EQUAL TO 2 HAE attacks per month, laryngeal attacks, etc.)?	☐ Yes Proceed to question **5**	☐ No **STOP** Coverage not approved
5. Is the patient currently receiving another drug for HAE prophylaxis (for example, Orladeyo, Takhzyro, Cinryze or Haegarda will be used concomitantly)?	☐ Yes **STOP** Coverage not approved	☐ No **Sign and date below**

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

_____ _____
Prescriber Signature Date

[03 June 2026]

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