Prior Authorization Request Form for
Lanadelumab

JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE
7231 Parkway Drive, Suite 100, Hanover, MD 21076

USFHP Pharmacy Prior Authorization Form

FAX Completed Form and Applicable Progress Notes to: (410) 424-4037

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. Is the patient greater than or equal to 12 years of age?	☐ Yes Proceed to question 2	☐ No **STOP** Coverage not approved
2. Is the patient pregnant or breast feeding?	☐ Yes **STOP** Coverage not approved	☐ No Proceed to question 3
3. Has the patient been diagnosed with hereditary angioedema (HAE) Type I, II, or III (HAE with normal C1-esterase inhibitor)?	☐ Yes Proceed to question 4	☐ No **STOP** Coverage not approved
4. Is the requested medication being prescribed by an allergist, immunologist, or rheumatologist, or in consultation with an HAE specialist?	☐ Yes Proceed to question 5	☐ No **STOP** Coverage not approved
5. Does the patient experience GREATER THAN OR EQUAL TO 2 HAE attacks per month?	☐ Yes Proceed to question 6	☐ No **STOP** Coverage not approved
6. Has the patient tried and failed an attenuated androgen (danazol)?	☐ Yes **Sign and date below**	☐ No Proceed to question 7
7. Has the patient experienced or is expected to experience serious adverse effects from the use of an androgen (e.g., virilization of women, stroke, or myocardial infarction, venous thromboembolism)?	☐ Yes **Sign and date below**	☐ No Proceed to question 8

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8. Is the patient female and 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 _____

[05 September 2018]

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