

PRIOR AUTHORIZATION REQUEST FORM

Individual and Family Plans

Icatibant

Fax back to: (833) 605-4407 Phone: (215) 991-4300

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

Patient Name: Member Number: Date of Birth: Office Contact: Line of Business: Exchange - PA NPI: State Lic ID: Address: Address: City, State ZIP: Primary Phone: Specialty/facility name (if applicable): Primary Phone: BEQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that the standard review timeframe may seriously jeopardize the life of he enrollee or the enrollee's ability to regain maximum function. Drug Name: Strength: Directions / SIG: Please attach any pertinent medical history including labs and information for this member that may support approx Please answer the following questions and sign. Q1. Is this an initial or continuation request? Initial - Go to 2 Continuation - Go to 7 Q2. Does the patient have a documented diagnosis of hereditary angioedema (HAE)? Yes No Q3. Is there confirmation that lcatibant is being used for the treatment of acute hereditary angioedema (HAE) attacks? Yes No Q4. Is the patient 18 years of age or older? Yes No Q5. Is the patient prescribed other drugs indicated for acute treatment of hereditary	Patient Name:				
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PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	Prescriber Name:		
Q6. Is icatibant being the prescribed by or in consultation with an allergist, immunologist pulmologist or prescriber who specializes in the management of HAE?			
☐ Yes	□ No		
Q7. For continuation, is there documentation of r	reduction in severity or duration of attacks?		
☐ Yes	□ No		
Q8. Additional Information:			
Prescriber Signature	Date		

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