UPMC HEALTH PLAN

Berinert, Firazyr, & Kalbitor

Prior Authorization Form

IF THIS IS AN URGENT REQUEST, Please Call UPMC Health Plan Pharmacy Services.
Otherwise please return completed form to:

UPMC HEALTH PLAN PHARMACY SERVICES PHONE 800-396-4139 FAX 412-454-7722

PLEASE TYPE OR PRINT NEATLY

Please complete all sections of this form AND include details of past relevant medical treatment, which substantiates the need for an exception to using formulary alternatives, i.e. past prescription treatment failures, documented side effects, chart documentation, lab values, etc. Incomplete responses may delay this request.

Office Contact:		**Provider Specialty:**	
Provider First Name:		**Provider Last Name:**	
Provider Phone:		**Provider Fax:**	**Provider NPI #:**
Patient Name:	**Patient UPMC Health Plan ID Number:**	**Patient DOB:**	**Patient Age:**
Drug Requested:	**Strength:**	**Frequency:**	**Qty Dispensed:**

Generic equivalent drugs will be substituted for Brand name drugs unless you specifically indicate otherwise.

☐ **New medication** ☐ **Ongoing medication**	**If ongoing, provide date started:**	**If medication is ongoing, Did member Show improvement while on therapy?**	☐ **Yes** ☐ **No**

Diagnosis:

Please indicate place of administration: ☐ Physician Office ☐ Hospital/facility

Please provide facility/provider name and address:

Please indicate how medication will be billed:

☐ Billed directly by the provider via JCODE
Provide JCODE: _____
☐ Billed by a pharmacy and delivered to the provider
☐ Billed by a pharmacy and delivered to the patient

MEDICAL HISTORY

The member must have a diagnosis of Hereditary Angioedema (HAE) confirmed by the following lab values on 2 separate instances:

- **C4 complement level**
- **C1q complement level (not required for age under18)**
- **C1 esterase inhibitor antigenic level**
- **C1 esterase inhibitor functional level**

A copy of lab report with reference ranges is required.

Has the member received at least one dose of the requested medication as treatment for an acute HAE attack in the past? **Chart documentation of the member response and ability to tolerate the medication is required.**	❑ **Yes** ❑ **No**
Chart documentation sent?	❑ **Yes** ❑ **No**

Please provide any additional information which should be considered in the space below: