STATEMENT OF MEDICAL NECESSITY FOR HEREDITARY ANGIOEDEMA (HAE) PROPHYLAXIS THERAPY

Patient Information

Name (First, Middle, Last) _____ DOB: _____ / _____ /_____

Insurance Information

Primary Insurance _____ Policy ID #_____

Pharmacy Plan _____ Policy ID #_____

Diagnosis and Medication Rationale

In addition to completing the information below, please provide supporting clinical documentation to the insurer.

Diagnosis Hereditary Angioedema ICD-10 D84.1 Date Diagnosed (Month/Year) _____/_____ Age at Diagnosis _____

Diagnosis confirmation: ❑ C1-inhibitor quantitative (antigenic) ❑ C1-inhibitor functional ❑ Family history or F12 genetic testing ❑ C4 therapy
❑ Other _____

Disease History: Please indicate location(s), number, and frequency of attacks:

Location of attacks:	❑ Abdominal	❑ Extremity	❑ Facial	❑ Laryngeal	❑ Urogenital
Number and frequency of attacks:	❑ #_____ ❑ Per month ❑ Per year	❑ #_____ ❑ Per month ❑ Per year	❑ #_____ ❑ Per month ❑ Per year	❑ #_____ ❑ Per month ❑ Per year	❑ #_____ ❑ Per month ❑ Per year

Has the patient experienced any of the following as a result of an HAE attack? Please check all that apply:

❑ Emergency room visit(s) Month/Year _____Comments _____

❑ Hospitalization(s) Month/Year _____Comments _____

❑ Intubation Month/Year _____Comments _____

Medication History: Please indicate previous medication(s) and results:

Medication:	❑ Androgens	❑ Antifibrinolytics	❑ Other _____
Results:	❑ Adverse effects intolerable ❑ Breakthrough attacks/ineffective ❑ Contraindicated ❑ Other _____	❑ Adverse effects intolerable ❑ Breakthrough attacks/ineffective ❑ Contraindicated ❑ Other _____	❑ Adverse effects intolerable ❑ Breakthrough attacks/ineffective ❑ Contraindicated ❑ Other _____

❑ Patient not on causal medications

Additional Comments _____

_____

Medication Recommendation _____

Dose: ❑ 60 IU/kg _____ Weight _____ ❑ kg ❑ lbs Frequency (times/week) _____

❑ Other _____

Physician Information and Authorization

Name (First, Last) _____ Provider ID# _____

I certify that the rationale for prescribing this medication is medically necessary and the information provided on this form is accurate to the best of my knowledge.

Physician Signature _____ Date _____ / _____ /_____