Jefferson Health Plans

PRIOR AUTHORIZATION REQUEST FORM

Individual and Family Plans

Haegarda

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.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	**Prescriber Name:**
Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Line of Business: □ Exchange - PA	NPI: State Lic ID:
Address:	Address:
City, State ZIP:	City, State ZIP:
Primary Phone:	**Specialty/facility name (if applicable):**

☐ REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that the standard review timeframe may seriously jeopardize the life or health of the 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 approval.

Please answer the following questions and sign.

Q1. Type of request:

☐ Initial - Go to 2 ☐ Continuation - Go to 6

Q2. Is the requested medication being prescribed by or in consultation with a prescriber who specializes in the management of HAE?

☐ Yes ☐ No

Q3. Is there documentation showing that the requested medication will not be used in combination with any other medication used for prophylaxis of HAE attacks?

☐ Yes ☐ No

Q4. Does the patient have C1 inhibitor deficiency or dysfunction as confirmed by laboratory testing and meets one of the following criteria?
A) C1 inhibitor (C1-INH) antigenic level below the lower limit of normal as defined by the laboratory performing the test, or
B) Normal C1-INH antigenic level and a low C1-INH functional level (functional C1-INH less than 50% or C1-INH functional level below the lower limit of normal as defined by the laboratory

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performing the test).
Please attach documentation.

☐ Yes ☐ No

Q5. Does the patient have normal C1 inhibitor as confirmed by laboratory testing and meets one of the following criteria?
A) Patient has an F12, angiopoietin-1, plasminogen, kininogen-1 (KNG1), heparan sulfate-glucosamine 3-O-sulfotransferase 6 (HS3ST6), or myoferlin (MYOF) gene mutation as confirmed by genetic testing
B) Patient has a documented family history of angioedema and the angioedema was refractory to a trial of high-dose antihistamine therapy (i.e., cetirizine at 40 mg per day or the equivalent) for at least one month.
Please attach documentation.

☐ Yes ☐ No

Q6. For reauthorization, has the patient experienced a significant reduction in frequency of attacks (e.g., = 50%) since starting treatment AND have they reduced the use of medications to treat acute attacks since starting treatment? Please provide documentation.

☐ Yes ☐ No

Q7. Additional Information:

Prescriber Signature

Date

v2025