

MEDICARE ADVANTAGE PRIOR AUTHORIZATION REQUEST FORM

Haegarda - Medicare

Phone: 215-991-4300 Fax back to: 866-371-3239

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.				
Member Name:		Prescriber Name:		
Member Number:		Fax:	Phone:	
Date of Birth:		Office Contact:		
Line of Business:	□ Medicare Advantage	NPI:	State Lic ID:	
Address:		Address:		
City, State ZIP:		City, State ZIP:	City, State ZIP:	
Primary Phone:		Specialty/facility name (if application)	Specialty/facility name (if applicable):	
REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that applying the 72 hour 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. Has the patient been previously approved for Haegarda? If YES, go to 2. If NO, go to 3				
☐ Yes		□ No		
Q2. Is there confirmation that the patient has had a reduction in severity or duration of attacks?				
☐ Yes		□ No		
Q3. Does the patient have a documented diagnosis of hereditary angioedema (HAE)?				
☐ Yes		□ No		
Q4. Is there confirmation that Haegarda is being used for the prophylaxis of HAE?				
☐ Yes		□ No		
	mber taking Haegarda in combina gainst HAE attacks?	ation with another approved t	reatment for	
☐ Yes		□ No		
Q6. Is the pati	ent 6 years of age or older?			

This telecopy transmission contains confidential information belonging to the sender that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reference to the contents of this document is strictly prohibited. If you have received this telecopy in error, please notify the sender immediately to arrange for the return of this document



MEDICARE ADVANTAGE PRIOR AUTHORIZATION REQUEST FORM

Haegarda - Medicare

Phone: 215-991-4300 Fax back to: 866-371-3239

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.

Member Name:	Prescriber Name:			
☐ Yes	□No			
Q7. Is Haegarda being prescribed by or in consultation with an allergist, immunologist, pulmonologist or prescriber who specializes in the management of HAE?				
☐ Yes	□ No			
Q8. Requested Duration:				
☐ 12 Months	☐ Other:			
Q9. Additional Information:				
Prescriber Signature	Date			
	v2025			

This telecopy transmission contains confidential information belonging to the sender that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reference to the contents of this document is strictly prohibited. If you have received this telecopy in error, please notify the sender immediately to arrange for the return of this document