Jefferson Health Plans

MEDICARE ADVANTAGE
PRIOR AUTHORIZATION REQUEST FORM

Icatibant - 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:
Primary Phone:	**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 Icatibant?

☐ 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 Icatibant is being used for the treatment of acute hereditary angioedema (HAE) attacks?

☐ Yes ☐ No

Q5. Is the patient 18 years of age or older?

☐ Yes ☐ No

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Member Name:	**Prescriber Name:**

Q6. Is the patient prescribed other drugs indicated for acute treatment of hereditary angioedema?

☐ Yes ☐ No

Q7. Is Icatibant being the prescribed by or in consultation with an allergist, immunologist, pulmonologist or prescriber who specializes in the management of HAE?

☐ Yes ☐ No

Q8. Additional Information:

Q9. Requested Duration:

☐ 12 Months ☐ Other

_____ _____

Prescriber Signature Date

v2025