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HAE Agents Prior Authorization of Benefits Form

CONTAINS CONFIDENTIAL PATIENT INFORMATION
Complete form in its entirety and fax to: Prior Authorization of Benefits Center at 844-474-3341.

1. Patient information

Patient name: _____
Patient ID #: _____
Patient DOB: _____
Date of Rx: _____
Patient phone #: _____
Patient email address: _____

2. Physician information

Prescribing physician: _____
Physician address: _____
Physician phone #: _____
Physician fax #: _____
Physician specialty: _____
Physician DEA: _____
Physician NPI #: _____
Physician email address: _____

3. Medication	4. Strength	5. Directions	6. Quantity per 30 days
			Specify:

7. Diagnosis:

8. Approval criteria: (Check all boxes that apply. Note: Any areas not filled out are considered not applicable to your patient and may affect the outcome of this request.)

☐ Yes ☐ No Does the client have a diagnosis of hereditary angioedema in the last 730 days?
☐ Yes ☐ No Patient has failed a 30-day treatment trial with at least one preferred agent(s) within the past 180 days.
☐ Yes ☐ No Patient has a documented allergy or contraindication to preferred agents in this class.
☐ Yes ☐ No Patient is being treated for stage-four advanced, metastatic cancer and associated conditions.
☐ Yes ☐ No Will client have concurrent therapy with another HAE prophylactic agent?

For the *Texas Medicaid Preferred Drug List*, please refer to the Texas Medicaid Vendor Drug Program website at **http://txvendordrug.com/formulary/formulary-search.asp**.

9. Physician signature

_____ _____
Prescriber or authorized signature Date

Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations and exclusions. The submitting provider certifies that the information provided is true, accurate and

complete and the requested services are medically indicated and necessary to the health of the patient. Note: Payment is subject to member eligibility. Authorization does not guarantee payment.