Orladeyo (berotralstat)
Prior Authorization Request Form

Caterpillar Prescription Drug Benefit
Phone: 877-228-7909 Fax: 800-424-7640

MEMBER'S LAST NAME: ___________________________ **MEMBER'S FIRST NAME:** ___________________________

Instructions: Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the authorization request). Information contained in this form is Protected Health Information under HIPAA.

☐ **URGENT**

MEMBER INFORMATION	
LAST NAME:	**FIRST NAME:**
PHONE NUMBER:	**DATE OF BIRTH:**
STREET ADDRESS:	
CITY:	**STATE:** **ZIP CODE:**
PATIENT INSURANCE ID NUMBER:	

☐ **MALE** ☐ **FEMALE** **HEIGHT (IN/CM):** ______ **WEIGHT (LB/KG):** ______ **ALLERGIES:** ______________________

IF YOU ARE NOT THE PATIENT OR THE PRESCRIBER, YOU WILL NEED TO SUBMIT A PHI DISCLOSURE AUTHORIZATION FORM WITH THIS REQUEST WHICH CAN BE FOUND AT THE FOLLOWING LINK: PRIMETHERAPEUTICS.COM/NOPP

PATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE): ____
AUTHORIZED REPRESENTATIVE'S PHONE NUMBER: ____

PRESCRIBER INFORMATION	
LAST NAME:	**FIRST NAME:**
PRESCRIBER SPECIALTY:	**EMAIL ADDRESS:**
NPI NUMBER:	**DEA NUMBER:**
PHONE NUMBER:	**FAX NUMBER:**
STREET ADDRESS:	
CITY:	**STATE:** **ZIP CODE:**
REQUESTOR (if different than prescriber)**:**	**OFFICE CONTACT PERSON:**

MEDICATION OR MEDICAL DISPENSING INFORMATION			
MEDICATION NAME:			
DOSE/STRENGTH:	**FREQUENCY:**	**LENGTH OF THERAPY/REFILLS:**	**QUANTITY:**
☐ **NEW THERAPY**	☐ **RENEWAL**	**IF RENEWAL:** DATE THERAPY INITIATED:	
DURATION OF THERAPY (SPECIFIC DATES):			

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1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION? ☐ YES (if yes, complete below) ☐ NO		
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE):	**DURATION OF THERAPY** (SPECIFY DATES):	**RESPONSE/REASON FOR FAILURE/ALLERGY:**

2. LIST DIAGNOSES:	**ICD-10:**
□ Hereditary Angioedema(HAE) □ Other diagnosis: ________________ICD-10_______________________	

3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.

Clinical Information:

Is this drug being prescribed to this patient as part of a treatment regimen specified within a sponsored clinical trial? □ Yes □ No

Does patient have a lab report showing a C1-INH functional level less than 50%? □ Yes □ No *Please submit lab report.*

Does patient have a lab report showing a C1-INH functional level of at least 50% but less than the assay's lower limit of normal PLUS a genetic test report documenting the patient has a SERPING1 gene mutation known or likely to be associated with HAE type 1 or 2? □ Yes □ No *Please submit lab reports.*

Does patient have a lab report showing a C4 level below the laboratory's listed lower limit of normal? □ Yes □ No *Please submit lab report.*

Does patient have a lab report showing a SERPING1 gene mutation known or likely to be associated with HAE type 1 or 2? □ Yes □ No *Please submit lab report.*

Does patient have a confirmed family history of C1-INH deficiency? □ Yes □ No *Please submit chart documentation.*

Has patient had at least 2 hereditary angioedema attacks within an 8-week period that required acute treatment, medical attention or caused significant functional impairment? □ Yes □ No *Please submit chart documentation.*

Has patient tried and failed Haegarda? □ Yes □ No *Please submit chart documentation.*

Has patient tried and failed Takhzyro? □ Yes □ No *Please submit chart documentation.*

Does patient have an absolute contraindication to Haegarda and Takhzyro? □ Yes □ No *Please submit chart documentation.*

Has patient had an inadequate response with attenuated androgens(such as danazol)? □ Yes □ No

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Does patient have at least one (1) contraindication to the use of attenuated androgens(such as danazol)?
□ **Yes** □ **No**

Please select one:
- □ **Hypersensitivity to the androgen or any component of the formulation**
- □ **Undiagnosed genital bleeding**
- □ **Pregnancy**
- □ **Breastfeeding**
- □ **Porphyria**
- □ **Impaired hepatic function**
- □ **Impaired renal function**
- □ **Impaired cardiac function**

Is patient going to be using any other HAE prophylactic agent such as Takhzyro(lanadelumab-flyo), Cinryze(C1 esterase inhibitor), or Haegarda(C1 esterase inhibitor) in combination with Haegarda? □ **Yes** □ **No**

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

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____

Please note: Not all drugs/diagnosis are covered on all plans. This request may be denied unless all required information is received.

ATTESTATION: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature or Electronic I.D. Verification: ________________________________ **Date:** ________________

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FAX THIS FORM TO: 800-424-7640
MAIL REQUESTS TO: Prime Therapeutics Management LLC
Attn: CP – 4201
P.O. Box 64811
St. Paul, MN 55164-0811

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