Takhzyro (lanadelumab-fylo) **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):				

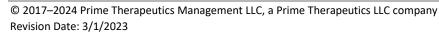
Continued on next page



Takhzyro (lanadelumab-fylo) Prior Authorization Request Form

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

MEMBER'S LAST NAME:	MEMBER'S FIRST NAME:			
1. HAS THE PATIENT TRIED ANY OTHER	R MEDICATIONS FOR THIS CONDITION?	YES (if yes, complete below) NO		
MEDICATION/THERAPY (SPECIFY	DURATION OF THERAPY (SPECIFY	RESPONSE/REASON FOR		
DRUG NAME AND DOSAGE):	DATES):	FAILURE/ALLERGY:		
2. LIST DIAGNOSES:		ICD-10:		
Hereditary Angioedema(HAE)				
Other diagnosis:ICD-1	U Code(s):			
3. REQUIRED CLINICAL INFORMATION PRIOR AUTHORIZATION.	: PLEASE PROVIDE ALL RELEVANT CLINIC	AL INFORMATION TO SUPPORT A		
Clinical Information:				
Initial Request: Is the prescriber an allergist or immun	ologist? 🗆 Yes 🗆 No			
Does patient have a functional C1-inhibitor level equal to or less than 40% of normal? Ves No Please submit lab report.				
Does patient have a functional C1-inhibitor level between 40-50%(inclusive) of normal? Output Yes Output Not Please submit lab report.				
Is patient's serum C4 level below norn	nal range? 🗆 Yes 🗆 No 🛛 Please subm	it lab report.		
Did the patient's first symptoms of angioedema occur at 30 years or younger? Yes No Please submit chart notes.				
Does the patient have a family history of hereditary angioedema(HAE)? Ves No Please submit chart notes.				
Is the patient's serum C1q level within normal range? 🗆 Yes 🗆 No				
Please submit lab report.	-			
Does the patient have angioedema at Please submit chart notes.	tacks at least one attack every 12 weeks	s? □ Yes □ No		
As patient been treated and had an i □ Yes □ No Please submit chart no	nadequate response with attenuated a ptes.	nurogens(such as danazol)?		
Continued on next page				





Takhzyro (lanadelumab-fylo) Prior Authorization Request Form

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

MEMBER'S LAST NAME: _____

MEMBER'S FIRST NAME:

Does patient h	ave at least one contraindication to the use of attenuate	ed androgens(such as danazol)? Yes No			
Please submit					
0	Hypersensitivity to the androgen or any component of	the formulation;			
0					
0					
0					
0					
0					
0					
0	Impaired cardiac function				
Will patient be Takhzyro?	e using Cinryze(C1 esterase inhibitor) or Haegarda(C1 est Yes 🛛 No	erase inhibitor) in combination with			
Renewal Requ	est:				
	inuing to demonstrate a positive clinical response? <pre>□ Ye</pre>	es 🗆 No Please submit chart notes.			
	0				
Will patient be using Cinryze(C1 esterase inhibitor) or Haegarda(C1 esterase inhibitor) in combination with Takhzyro? u Yes u 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?					
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: Date:					
CONFIDENTIALITY					

CONFIDENTIALITY NOTICE: The documents accompanying this transmission contain confidential health information that is legally privileged. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately (via return FAX) and arrange for the return or destruction of these documents.

FAX THIS FORM TO: 800-424-7640

MAIL REQUESTS TO: Prime Therapeutics Management Prior Authorization Program

Attn: CP - 4201 P.O. Box 64811

St. Paul, MN 55164-0811

