Prescription Medication Prior Authorization Request Form

☐ Standard PA Request ☐ Urgent/Expedited PA Request

Please fill out all sections and attach any important documentation such as chart notes or lab results to support the PA request.
Once completed, to WithMe Health via fax at **1-866-678-8301**

Patient Information

Patient Name (Last, First, MI):		
Member ID Number:	Date of Birth:	Patient Phone Number:
Patient Address:		
Patient's Authorized Representative (If applicable):		Authorized Rep Phone Number:

Provider Information

Requesting Provider's Name:		
NPI:	Specialty:	
Office Address:		
Office Phone:	Office Fax:	
Office Contact Name:	Phone:	Fax:
Dispensing Pharmacy Name/Place of Service:	Phone:	Fax:

Requested Medication Information

Medication Name and Strength:	
Dose and Frequency (Sig):	
Qty Per 30 Days:	Expected Duration of Therapy:
ICD-10(s):	Diagnosis:

Please check one of the boxes below. If established, please include therapy start date:

☐ New Therapy ☐ Samples ☐ Clinical Trial ☐ Established Date Therapy Started: _____

Previous Therapies Used for Diagnosis (Rx and OTC products)

Medication Name, Strength, Dose, Frequency	Dates Used	Outcome of Therapy (e.g., Ineffective, Not Tolerated)

Medical Rationale for Use of Requested Medication (**Please attach chart notes, lab work etc. when submitting this request. If applicable, please include why formulary therapies may be contraindicated for this patient.** Please also include which therapies will be used along with the requested medication. If patient is established on the requested medication, please include recent documentation of how the patient has responded to therapy.):

Disease State Specific Questions

If patient has Hereditary Angioedema (Types I, II, or HAE with Normal C1 Inhibitor) - Acute ("as needed") Treatment, please provide the following information:

1. Is the requested medication Icatibant (Firazyr), Berinert (pdC1-INH), and Kalbitor (ecallantide) or Ruconest (rhC1-INH)? ☐ Yes ☐ No
2. Does the patient have a diagnosis of HAE Type I or Type II, or HAE with Normal C1 Inhibitor that has been established by, or in consultation with a provider specializing in allergy, immunology, or hematology? ☐ Yes ☐ No
3. For Type I and Type II HAE, please provide the following clinical documentation (including, but not limited to chart notes):
   - ☐ serum C4 and C1-INH (antigenic or functional level) that are below the limits of the laboratory's normal reference range.
   - ☐ Family history of HAE
   - ☐ Normal level of serum C1q antigenic protein based on the laboratory's normal reference range
4. Is the treatment being used in conjunction or concomitantly with other HAE- specific therapies for acute treatment, e.g., Berinert (pdC1-INH), Kalbitor (ecallantide), icatibant (Firazyr), or Ruconest (rhC1-INH)? ☐ Yes ☐ No
5. What is the age of the patient? _____

If patient has Hereditary Angioedema (Type I or Type II) – Prophylactic ("scheduled") treatment, please provide the following information:

1. Is the requested medication Cinryze (pdC1-INH), Haegarda (pdC1-INH) or Takhzyro (lanadelumab)? ☐ Yes ☐ No
2. Does the patient have a diagnosis of Type I or Type II HAE that has been established by or in consultation with a provider specializing in allergy, immunology, or hematology? ☐ Yes ☐ No
3. For Type I and Type II HAE, please provide the following clinical documentation (including, but not limited to chart notes):
   - ☐ serum C4 and C1-INH (antigenic or functional level) that are below the limits of the laboratory's normal reference range.
   - ☐ Family history of HAE
   - ☐ Normal level of serum C1q antigenic protein based on the laboratory's normal reference range
4. Has the patient been evaluated for potentially treatable triggers of HAE attacks and is maximally managed with respect to avoiding triggers? ☐ Yes ☐ No
5. Does the patient have a history of attacks that are considered severe with swelling of the face, throat, or gastrointestinal tract. Severe is defined as events that significantly interrupt usual daily activity despite short term symptomatic treatment, as documented in clinical documentation (including, but not limited to chart notes or HAE calendar)? ☐ Yes ☐ No
6. Has the patient had prior treatment course of at least 3-months with attenuated androgens (e.g. danazol, oxandrolone) has been ineffective, defined as a lack of reduction in the frequency of attacks, or a severe attack during the treatment course? ☐ Yes ☐ No
7. If attenuated androgens are contraindicated or not tolerated, has it been determined that an antifibrinolytic (tranexamic acid or aminocaproic acid) was ineffective, contraindicated, or not tolerated after at least a 3-month treatment course? ☐ Yes ☐ No

8. Will the treatment be used in conjunction with other HAE-specific therapies for the prophylaxis of HAE attacks? ☐ Yes ☐ No

9. What is the age of the patient? _____

If the patient requires Acquired Angioedema – Acute ("as needed") Treatments, please provide the following information:

1. Is the requested medication: Icatibant (Firazyr), Berinert (pdC1-INH), or Kalbitor (ecallantide)? ☐ Yes ☐ No
2. Was the diagnosis of acquired angioedema has been established by, or in consultation with a specialist in allergy, immunology, or hematology? ☐ Yes ☐ No
3. Please provide the following clinical documentation (including, but not limited to chart notes):
   - ☐ serum C4 and C1-INH (antigenic or functional level) that are below the limits of the laboratory's normal reference range.
   - ☐ The patient has been evaluated for an underlying B-cell lymphoproliferative disorder
   - ☐ Normal level of serum C1q antigenic protein based on the laboratory's normal reference range

4. What is the age of the patient? _____

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that documentation supporting this information is available for review if requested by WithMe Health, the health plan sponsor, or, if applicable, a state or federal regulatory agency.

_____ _____

Provider Signature Date