AcariaHealth™ An envolve Solution

envolve™ Pharmacy Solutions

Phone: 855-304-5580 | Fax: 855-521-1728

Hereditary Angioedema (HAE) Therapy

Prior Authorization Form/ Prescription

Date: _____ Date Medication Required:_____

Ship to: ❍ Physician ❍ Patient's Home ❍ Other _____

Patient Information

Last Name:	First Name:	Middle:	DOB: ____/____/_____
Address:	City:	State:	Zip:
Daytime Phone:	Evening Phone:	Sex: ☐ Male ☐ Female	

Insurance Information (Attach Copies of cards)

Primary Insurance:		Secondary Insurance:	
ID #	Group #	ID #	Group #
City:	State:	City:	State:

Physician Information

Name:	Specialty:	NPI:	
Address:	City:	State:	Zip:
Phone # ( )	Secure Fax #: ( )	Office contact:	

Prescription Information

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
☐ Firazyr ☐ Kalbitor ☐ Berinert ☐ Cinryze				

Primary Diagnosis

Primary ICD-9/ICD-10 Code: _____

☐ Hereditary Angioedema (HAE) ☐ Other_____

Clinical Information

***** Please submit supporting clinical documentation*****

☐ **INITIAL THERAPY** ☐ **CONTINUATION OF THERAPY**; Therapy start date: _____

Patient's weight: _____ kg Dose: _____ units/kg

1. Has HAE confirmed by decreased serum levels of C4 **AND** absence or marked decrease (less than 50% of normal) of the level or function of C1-INH (C1-esterase inhibitor)? ☐ Yes ☐ No
2. Does the patient have HAE type 3? ☐ Yes ☐ No
3. Reason for use of medication:
   - ☐ Treatment of acute abdominal, facial or laryngeal attacks of HAE
   - ☐ Treatment of acute HAE attack
   - ☐ Routine prophylaxis

For Kalbitor therapy ONLY

4. Will the medication be administered in a setting equipped to provide medical support for anaphylaxis and HAE? ☐ Yes ☐ No

For continuation of therapy ONLY,

5. Is the patient tolerating and demonstrating effective response to the treatment? ☐ Yes ☐ No

Physician's Signature _____ **Date:** _____ ☐ DAW