Haegarda® (C1 esterase inhibitor, human) Medication Precertification Request

(All fields must be completed and legible for precertification review.)

Aetna Precertification Notification
Phone: 1-866-752-7021
FAX: 1-888-267-3277

For Medicare Advantage Part B: Please Use Medicare Request Form

Please indicate: ☐ Start of treatment: Start date ____/____/____
☐ Continuation of therapy: Date of last treatment ____/____/____

Precertification Requested By: _____ Phone: _____ Fax: _____

A. PATIENT INFORMATION

First Name:	Last Name:		
Address:	City:	State:	ZIP:
Home Phone:	Work Phone:	Cell Phone:	
DOB:	Allergies:	Email:	

Current Weight: _____ lbs or _____ kgs Height: _____ inches or _____ cms

B. INSURANCE INFORMATION

Aetna Member ID #: _____ Does patient have other coverage? ☐ Yes ☐ No
Group #: _____ If yes, provide ID#: _____ Carrier Name: _____
Insured: _____ Insured: _____

Medicare: ☐ Yes ☐ No If yes, provide ID #: _____ **Medicaid**: ☐ Yes ☐ No If yes, provide ID #: _____

C. PRESCRIBER INFORMATION

First Name:		Last Name: *(Check One)*: ☐ M.D. ☐ D.O. ☐ N.P. ☐ P.A.			
Address:		City:	State:	ZIP:	
Phone:	Fax:	St Lic #:	NPI #:	DEA #:	UPIN:
Provider Email:		Office Contact Name:		Phone:	

Specialty *(Check one)*: ☐ **Allergist** ☐ **Immunologist** ☐ **Other**: _____

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration:
☐ Self-administered ☐ Physician's Office
☐ Outpatient Infusion Center Phone: _____
Center Name: _____
☐ Home Infusion Center Phone: _____
Agency Name: _____
☐ Administration code(s) (CPT): _____
Address: _____

Dispensing Provider/Pharmacy: *(Patient selected choice)*
☐ Physician's Office ☐ Retail Pharmacy
☐ Specialty Pharmacy ☐ Other: _____
Name: _____
Address: _____
Phone: _____ Fax: _____
TIN: _____ PIN: _____

E. PRODUCT INFORMATION

Request is for: Haegarda (C1 esterase inhibitor, human) Dose: _____ **Frequency:** _____

F. DIAGNOSIS INFORMATION – Please indicate primary ICD Code and specify any other where applicable.

Primary ICD Code: _____ Secondary ICD Code: _____ Other ICD Code: _____

G. CLINICAL INFORMATION – Required clinical information must be completed in its entirety for all precertification requests.

For All Requests (clinical documentation required for all requests):

☐ Yes ☐ No Is the requested medication being used for the prevention of hereditary angioedema (HAE) attacks?
☐ Yes ☐ No Will the requested medication be used in combination with any other medication used for the prophylaxis of hereditary angioedema (HAE) attacks?
Please indicate how many hereditary angioedema (HAE) attacks the patient has per month: _____
☐ Yes ☐ No Is the requested medication prescribed by or in consultation with a prescriber who specializes in management of hereditary angioedema (HAE)?
Which of the following applies to the patient?

☐ **Hereditary angioedema (HAE) with C1 inhibitor deficiency or dysfunction confirmed by laboratory testing**
Please indicate which of the following conditions the patient has/had at the time of diagnosis:
- ☐ A C1 inhibitor (C1-INH) antigenic level below the lower limit of normal as defined by the laboratory performing the test
- ☐ A normal C1-INH antigenic level and a low C1-INH functional level (functional C1-INH less than 50% or C1-INH functional level below the lower limit of normal as defined by the laboratory performing the test)
- ☐ Other

☐ **Hereditary angioedema (HAE) with normal C1 inhibitor confirmed by laboratory testing**
Please indicate which of the following conditions the patient has/had at the time of diagnosis:
- ☐ F12, angiopoietin-1, plasminogen, kininogen-1 (KNG1), heparan sulfate-glucosamine 3-0 sulfotransferase 6 (HS3ST6) or myoferlin (MYOF) gene mutation as confirmed by genetic testing
- ☐ **Both** of the following: 1). Angioedema refractory to a trial of high-dose antihistamine therapy (i.e., cetirizine at 40 mg per day or the equivalent) for at least one month **AND** 2). Family history of angioedema
- ☐ Other

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Patient First Name	Patient Last Name	Patient Phone	Patient DOB

G. CLINICAL INFORMATION *(continued)* – Required clinical information must be completed in its entirety for all precertification requests.

For Continuation of Therapy Requests (clinical documentation required for all requests):

☐ Yes ☐ No Has the patient experienced a significant reduction in frequency of acute attacks (e.g., >= 50%) since starting treatment?

☐ Yes ☐ No Has the patient reduced the use of medications to treat acute attacks since starting treatment with the requested medication?

H. ACKNOWLEDGEMENT

Request Completed By *(Signature Required):* _____ **Date:** ____/____/____

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

The plan may request additional information or clarification, if needed, to evaluate requests.