Takhzyro® (lanadelumab-flyo) 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 #: _____
Group #: _____
Insured: _____

Does patient have other coverage? ☐ Yes ☐ No
If yes, provide ID#: _____ Carrier Name: _____
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: Takhzyro (lanadelumab-flyo) 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?
☐ Yes ☐ No Is the requested medication prescribed by or in consultation with a prescriber who specializes in the management of hereditary angioedema (HAE)?

Please indicate how many hereditary angioedema (HAE) attacks the patient has per month: _____

Which of the following applies to the patient at the time of diagnosis?

☐ **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?
☐ Yes ☐ No Is the requested medication being dosed every 4 weeks?
→ ☐ Yes ☐ No Has the patient been well-controlled on therapy for more than 6 months?
→ ☐ Yes ☐ No Has dosing every 4 weeks been considered?

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.