



Haegarda (C1 esterase inhibitor, human) Medication Precertification Request

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(All fields must be completed and legible for Precertification Review.)

Aetna Precertification Notification
503 Sunport Lane, Orlando, FL 32809

Phone: 1-866-752-7021

FAX: 1-888-267-3277

For Medicare Advantage Part B:

Phone: 1-866-503-0857

FAX: 1-844-268-7263

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? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Group #: _____		If yes, provide ID#: _____		Carrier Name: _____	
Insured: _____		Insured: _____			
Medicare: <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, provide ID #: _____		Medicaid: <input type="checkbox"/> Yes <input type="checkbox"/> No	
				If yes, provide ID #: _____	

C. PRESCRIBER INFORMATION

First Name:		Last Name: _____ (Check One): <input type="checkbox"/> M.D. <input type="checkbox"/> D.O. <input type="checkbox"/> N.P. <input type="checkbox"/> P.A.			
Address:		City:		State:	ZIP:
Phone:	Fax:	St Lic #:	NPI #:	DEA #:	UPIN:
Provider Email:		Office Contact Name:			Phone:
Specialty (Check one): <input type="checkbox"/> Allergist <input type="checkbox"/> Immunologist <input type="checkbox"/> Other: _____					

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration:		Dispensing Provider/Pharmacy: (Patient selected choice)			
<input type="checkbox"/> Self-administered <input type="checkbox"/> Physician's Office		<input type="checkbox"/> Physician's Office <input type="checkbox"/> Retail Pharmacy			
<input type="checkbox"/> Outpatient Infusion Center Phone: _____		<input type="checkbox"/> Specialty Pharmacy <input type="checkbox"/> Other: _____			
Center Name: _____		Name: _____			
<input type="checkbox"/> Home Infusion Center Phone: _____		Address: _____			
Agency Name: _____		Phone: _____ Fax: _____			
<input type="checkbox"/> Administration code(s) (CPT): _____		TIN: _____ PIN: _____			
Address: _____					

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):

Please indicate the diagnosis:

Hereditary angioedema (HAE) with C1 inhibitor deficiency or dysfunction confirmed by laboratory testing:
Please indicate which of the following conditions does the patient have:
 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)

HAE with normal C1 inhibitor confirmed by laboratory testing:
Please indicate which of the following conditions does the patient have:
 F12, angiotensinogen 1, or plasminogen gene mutation as confirmed by genetic testing
 Family history of angioedema and angioedema refractory to a trial of high-dose antihistamine (e.g. cetirizine) for at least one month

Yes No Is the requested medication being used to prevent future HAE attacks?
 Yes No Will the requested medication be used in combination with Cinryze or Takzyro?

For Continuation of Therapy Requests:

Yes No Has the patient experienced reduction in frequency, severity, and/or duration of attacks since starting treatment?

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.