



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
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):

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 HAE attacks?

Please indicate how many HAE attacks the patient has per month: _____

Which of the following applies to the patient?

Hereditary angioedema (HAE) with C1 inhibitor deficiency or dysfunction confirmed by laboratory testing

Yes No Does the patient have a C4 level below the lower limit of normal as defined by the laboratory performing the test?

Please indicate which of the following conditions the patient has:

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

HAE with normal C1 inhibitor confirmed by laboratory testing

Please indicate which of the following conditions the patient has:

F12, angiotensin-1, plasminogen, kininogen-1 (KNG1), heparan sulfate-glucosamine 3-O 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

Continued on next page



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Patient First Name	Patient Last Name	Patient Phone	Patient DOB
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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 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.