Member Name: _____ Member ID: _____ Member DOB: _____

Drug Name: _____ Strength: _____ Directions: _____

Physician Name: _____ Physician Phone #: _____ Specialty: _____

Physician Fax #: _____ Pharmacy Name: _____Pharmacy Phone: _____

Horizon NJ Health

Hereditary Angioedema – Medical Necessity Request

*****Complete page 1 for Initial and Subsequent/Renewal Requests *****

General Questions:

- What is the member's current weight? _____lbs Date Taken: _____
  _____ kg

- What is the prescriber's specialty? □ Allergy □ Immunology □ Other: _____

  - If Other, is this medication being prescribed in consultation with an allergist/immunologist or a physician that specializes in the treatment of Hereditary Angioedema (HAE) or related disorders? **Yes or No**

Diagnosis Information (please indicate the diagnosis and answer the related questions):

☐ Prophylaxis of Hereditary Angioedema (HAE)

- Have medications known to cause angioedema (i.e. ACE-Inhibitors, estrogen-containing medications, angiotensin II receptor blockers) been evaluated and discontinued when appropriate? **Yes or No**

  - If No, please provide clinical reason_____

- Will the member be using the requested medication in combination with other approved treatments for prophylaxis against HAE attacks? **Yes or No**

  If Yes, what other medication(s) will the member be receiving along with the requested medication?
  _____

☐ Acute treatment of Hereditary Angioedema (HAE)

- Have medications known to cause angioedema (i.e. ACE-Inhibitors, estrogen-containing medications, angiotensin II receptor blockers) been evaluated and discontinued when appropriate? **Yes or No**

  - If No, please provide clinical reason_____

- Will the member be using the requested medication in combination with other approved treatments for acute HAE attacks? **Yes or No**

  If Yes, what other medication(s) will the member be receiving along with the requested medication?
  _____

☐ Other: _____

Physician office's signature*_____ Print Name_____

***Form must be completed and signed by physician or licensed representative from the physician's office**