



Please complete ALL information below and fax your request to 1-888-671-5285

Takhzyro™ Coverage Determination Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

| Member Information (required) | | | Provider Information (required) | | |
|-------------------------------|--------|------|---------------------------------|-----------------|------|
| Member Name: | | | Provider Name: | | |
| Insurance ID#: | | | NPI#: | Specialty: | |
| Date of Birth: | | | Office Phone: | | |
| Street Address: | | | Office Fax: | Office Contact: | |
| City: | State: | Zip: | Office Street Address: | | |
| Phone: | | | City: | State: | Zip: |

| Medication Information (required) | | |
|--|-----------|---------------------|
| Medication Name: Select one of the following: <input type="checkbox"/> Request is for GENERIC <input type="checkbox"/> Request is for BRAND (unable to take the generic) <input type="checkbox"/> Check if request is for continuation of therapy | Strength: | Dosage Form: |
| | | Directions for Use: |

| Clinical Information (required) |
|---|
| Select the Type of Coverage Determination Requested: <input type="checkbox"/> Prior Authorization- Request is for a drug that requires prior authorization under the plan. |
| Select the diagnosis below: <input type="checkbox"/> Hereditary angioedema (HAE) <input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____ |
| Clinical Information: Does the patient have history of laryngeal edema or airway compromise with an episode of HAE or a history of at least 2 HAE attacks per month? <input type="checkbox"/> Yes <input type="checkbox"/> No Has the patient had an inadequate response or inability to tolerate 17 alpha-alkylated androgens (e.g., danazol, oxandrolone, stanozolol) or anti-fibrinolytic agents (e.g., epsilon aminocaproic acid, tranexamic acid) for HAE prophylaxis? <input type="checkbox"/> Yes <input type="checkbox"/> No Is Takhzyro prescribed by an allergist or immunologist? <input type="checkbox"/> Yes <input type="checkbox"/> No |

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note: This request may be denied unless all required information is received.

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