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: ❑ Request is for **GENERIC** ❑ Request is for **BRAND** (unable to take the generic)	Strength:	Dosage Form:
❑ Check if request is for **continuation of therapy**	Directions for Use:	

Clinical Information (required)

Select the Type of Coverage Determination Requested:

❑ **Prior Authorization**- Request is for a drug that requires prior authorization under the plan.

Select the diagnosis below:

❑ Hereditary angioedema (HAE)

❑ 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? ❑ **Yes** ❑ **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? ❑ **Yes** ❑ **No**

Is Takhzyro prescribed by an allergist or immunologist? ❑ **Yes** ❑ **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.