

Statement of Medical Necessity for the treatment of Hereditary Angioedema (HAE)

Patient Information	Name (First, Middle Initial, Last) _____ <input type="checkbox"/> Male <input type="checkbox"/> Female		DOB: _____ / _____ / _____ Month Day Year			
	Street Address _____ (_____) _____		City _____	State _____	Zip Code _____	
	Home Telephone _____		Mobile Telephone _____	Work Telephone _____ (_____) _____		
Insurance Information	Primary Insurance _____		Insurance Telephone _____			
	Policy ID # _____	Group # _____	Policy Holder Name (First, Last) and Relationship to Patient _____ (_____) _____			
	Pharmacy Plan Name _____		Pharmacy Plan Telephone _____			
Diagnosis and Treatment Rationale	Policy ID # _____ Group # _____ Rx BIN # _____ Rx PCN # _____					
	In addition to completing the information below, please include supporting clinical documentation to be provided to the insurance provider.					
	Diagnosis: Hereditary Angioedema ICD-10 D84.1		Date Diagnosed: _____ / _____		Age at Diagnosis: _____	
	Diagnosis confirmation: <input type="checkbox"/> C1-inhibitor quantitative (antigenic)		<input type="checkbox"/> C1-inhibitor functional		<input type="checkbox"/> Family history and C1-inhibitor testing	
	<input type="checkbox"/> Other: _____					
	Disease History: Please indicate location(s), number, and frequency of attacks:					
	Location of attacks: <input type="checkbox"/> Abdominal <input type="checkbox"/> Extremity <input type="checkbox"/> Facial <input type="checkbox"/> Laryngeal <input type="checkbox"/> Urogenital					
	Number of attacks: <input type="checkbox"/> 1 - 2 <input type="checkbox"/> 3 - 4 <input type="checkbox"/> 5 - 6 <input type="checkbox"/> > 6					
	Frequency of attacks: <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly <input type="checkbox"/> Yearly					
	Has the patient experienced any of the following as a result of an HAE attack? Please check all that apply:					
<input type="checkbox"/> Emergency room visit(s) Comment: _____						
<input type="checkbox"/> Hospitalization(s) Comment: _____						
<input type="checkbox"/> Intubation _____ / _____ / _____ Comment: _____ Month Year						
Treatment History: Please indicate previous treatment(s) and results:						
Treatment: <input type="checkbox"/> androgens <input type="checkbox"/> C1 esterase inhibitor <input type="checkbox"/> kallikrein inhibitor <input type="checkbox"/> other _____						
Results: <input type="checkbox"/> adverse effects <input type="checkbox"/> breakthrough attacks <input type="checkbox"/> contraindicated <input type="checkbox"/> effective <input type="checkbox"/> intolerable <input type="checkbox"/> other _____						
Additional comments: _____						
Treatment Recommendation: _____ NDC: _____						
Dose: _____ Frequency: _____						
Physician Information and Authorization	Name (First, Last) _____		Office Contact _____			
	Street Address _____ (_____) _____		City _____	State _____	Zip Code _____	
	Telephone _____		Fax _____	National Provider ID # _____		
	I certify that the rationale for prescribing this treatment is medically necessary and the information provided on this form is accurate to the best of my knowledge.					
Physician Signature _____				Date _____		