Priority Health Medicare prior authorization form

Fax completed form to: 877.974.4411 toll free, or 616.942.8206

This form applies to: ☐ **Medicare Part B** ☒ **Medicare Part D**

This request is: ☐ **Expedited request** ☐ **Standard request**

Your request will be expedited if you haven't gotten the prescription and Priority Health Medicare determines, or your prescriber tells us, that your life or health may be at risk by waiting.

Firazyr® (icatibant)

Member

Last Name: _____ First Name: _____

ID #: _____ DOB: _____ Gender: _____

Primary Care Physician: _____

Requesting Provider: _____ Prov. Phone: _____ Prov. Fax: _____

Provider Address: _____

Provider NPI: _____ Contact Name: _____

Provider Signature: _____ Date: _____

Product Information

☐ New request ☐ Continuation request

Drug product: ☐ Firazyr 30 mg/3 mL

Start date (or date of next dose): _____

Date of last dose (if applicable): _____

Dosing frequency: _____

Drug cost information

The wholesale acquisition cost for one syringe is $9,078. The annual cost of treatment with this drug will vary depending on the patient's circumstances.

Precertification Requirements

Before this drug is covered, the patient must meet all of the following requirements:

1. Diagnosis of hereditary angioedema (HAE)
   a. For HAE Type I and II, submission of two sets of C4, C1-INH protein, and C1-INH function lab results confirming diagnosis is required
2. Must be 18 years of age or older
3. Firazyr is being used only for the treatment of acute attacks

Medically accepted indication

This drug is only covered under Medicare Part D when it is used for a medically accepted indication. A medically accepted indication is a use of the drug that is *either*:

- approved by the Food and Drug Administration. (That is, the Food and Drug Administration has approved the drug for the diagnosis or condition for which it is being prescribed.)
- — *or* — supported by certain reference books. (These reference books are the American Hospital Formulary Service Drug Information and the DRUGDEX Information System)

All fields must be complete and legible for review. Your office will receive a response via fax. No changes made since 11/2017

Last reviewed 09/2019

Priority Health Precertification Documentation

A. What condition is this drug being requested for?

☐ Hereditary angioedema type I or II (two sets of C4, C1-INH protein, and C1-INH function lab results must be submitted to Priority Health)
☐ Hereditary angioedema type III (HAE with normal C1-INH)
☐ *Other – the patient's condition is:* _____
Rationale for use: _____

B. Will the patient be using Firazyr for acute or prophylactic treatment?

☐ Acute
☐ Prophylactic

Priority Health Medicare exception request

Do you believe one or more of the prior authorization requirements should be waived? ☐ Yes ☐ No
If yes, you must provide a statement explaining the medical reason why the exception should be approved.

Would Firazyr likely be the most effective option for this patient?

☐ No
☐ Yes, because: _____

If the patient is currently using Firazyr, would changing the patient's current regimen likely result in adverse effects for the patient?

☐ No
☐ Yes, because: _____

Additional information

When authorized, Priority Health will cover up to 3 syringes (9 mL) of Firazyr every 15 days.

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