URGENT – 24 HOURS

UnitedHealthcare Community Plan

FIRAZYR / BERINERT

PRIOR AUTHORIZATION REQUEST FORM

Complete ENTIRE form and Fax to: 866-940-7328

SECTION A - PATIENT INFORMATION		
Today's Date:	First Name:	Last Name:
Member ID #:	Address:	
City:	State:	Zip:
Phone:	DOB:	Allergies:
Primary Insurance:	Policy #:	Group #:

Is the requested medication NEW ☐ or a CONTINUATION of THERAPY ☐? If so, start date:_____

Is this patient currently hospitalized? ☐Yes ☐No

SECTION B - PHYSICIAN INFORMATION				
First Name:		Last Name:		M.D./D.O.
Address:		City:	State:	Zip:
Phone:	Fax:	NPI #:	Specialty:	
Office Contact Name / Fax Attention to:				

Medication: **Strength:**

Directions for use:

Diagnosis (Please be specific & provide as much information as possible)**:** **ICD 10 Code:**

SECTION C – CLINICAL INFORMATION

Is the prescriber an immunologist, allergist, or rheumatologist? ☐ **Yes** ☐ **No**

Firazyr Requests:

Is Firazyr being prescribed for the treatment of acute Hereditary Angioedema? ☐ **Yes** ☐ **No**

Berinert Requests:

Is Berinert being prescribed for the treatment of acute abdominal, facial, or laryngeal Hereditary Angioedema attacks? ☐ **Yes** ☐ **No**

Additional Clinical Information to Support this Request:

_____

_____

Physician Signature: _____ **Date:** _____