

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:** _____