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

Patient Information

Name (First, Middle Initial, Last) ☐ Male ☐ 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

Policy ID # Group # Rx BIN # Rx PCN #

Diagnosis and Treatment Rationale

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: Month Year Age at Diagnosis:

Diagnosis confirmation: ☐ C1-inhibitor quantitative (antigenic) ☐ C1-inhibitor functional ☐ Family history and C1-inhibitor testing ☐ Other:

Disease History:

Please indicate location(s), number, and frequency of attacks:

	Abdominal	Extremity	Facial	Laryngeal	Urogenital
Location of attacks:	☐	☐	☐	☐	☐
Number of attacks:	☐ 1 - 2 ☐ 3 - 4 ☐ 5 - 6 ☐ > 6	☐ 1 - 2 ☐ 3 - 4 ☐ 5 - 6 ☐ > 6	☐ 1 - 2 ☐ 3 - 4 ☐ 5 - 6 ☐ > 6	☐ 1 - 2 ☐ 3 - 4 ☐ 5 - 6 ☐ > 6	☐ 1 - 2 ☐ 3 - 4 ☐ 5 - 6 ☐ > 6
Frequency of attacks:	☐ Monthly ☐ Quarterly ☐ Yearly	☐ Monthly ☐ Quarterly ☐ Yearly	☐ Monthly ☐ Quarterly ☐ Yearly	☐ Monthly ☐ Quarterly ☐ Yearly	☐ Monthly ☐ Quarterly ☐ Yearly

Has the patient experienced any of the following as a result of an HAE attack? Please check all that apply:

☐ Emergency room visit(s) Comment:

☐ Hospitalization(s) Comment:

☐ Intubation Month Year Comment:

Treatment History:

Please indicate previous treatment(s) and results:

	androgens	B2 receptor antagonist	kallikrein inhibitor	other
Treatment:	☐	☐	☐	☐
Results:	☐ adverse effects ☐ breakthrough attacks ☐ contraindicated ☐ effective ☐ intolerable ☐ other	☐ adverse effects ☐ breakthrough attacks ☐ contraindicated ☐ effective ☐ intolerable ☐ other	☐ adverse effects ☐ breakthrough attacks ☐ contraindicated ☐ effective ☐ intolerable ☐ other	☐ adverse effects ☐ breakthrough attacks ☐ contraindicated ☐ effective ☐ intolerable ☐ 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