Reset Form

# 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:

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

| Treatment: | ☐ androgens | ☐ C1 esterase inhibitor | ☐ kallikrein inhibitor | ☐ other |
|---|---|---|---|---|
| Results: | ☐ adverse effects<br>☐ breakthrough attacks<br>☐ contraindicated<br>☐ effective<br>☐ intolerable<br>☐ other | ☐ adverse effects<br>☐ breakthrough attacks<br>☐ contraindicated<br>☐ effective<br>☐ intolerable<br>☐ other | ☐ adverse effects<br>☐ breakthrough attacks<br>☐ contraindicated<br>☐ effective<br>☐ intolerable<br>☐ other | ☐ adverse effects<br>☐ breakthrough attacks<br>☐ contraindicated<br>☐ effective<br>☐ intolerable<br>☐ 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