Horizon NJ Health

Hereditary Angioedema – Medical Necessity Request

**Complete page 1 for Initial and Subsequent/Renewal Requests**

**General Questions:**

- What is the member's current weight? ______ lbs Date Taken: _______
  ______ kg

- What is the prescriber's specialty? □ Allergy □ Immunology □ Other: ___________________________
  ○ If Other, is this medication being prescribed in consultation with an allergist/immunologist or a physician that specializes in the treatment of Hereditary Angioedema (HAE) or related disorders?  Yes or No

**Diagnosis Information** (please indicate the diagnosis and answer the related questions):

□ Prophylaxis of Hereditary Angioedema (HAE)

- Have medications known to cause angioedema (i.e. ACE-Inhibitors, estrogen-containing medications, angiotensin II receptor blockers) been evaluated and discontinued when appropriate? Yes or No
  - If No, please provide clinical reason______________________________

- Will the member be using the requested medication in combination with other approved treatments for prophylaxis against HAE attacks? Yes or No
  - If Yes, what other medication(s) will the member be receiving along with the requested medication?

□ Acute treatment of Hereditary Angioedema (HAE)

- Have medications known to cause angioedema (i.e. ACE-Inhibitors, estrogen-containing medications, angiotensin II receptor blockers) been evaluated and discontinued when appropriate? Yes or No
  - If No, please provide clinical reason______________________________

- Will the member be using the requested medication in combination with other approved treatments for acute HAE attacks? Yes or No
  - If Yes, what other medication(s) will the member be receiving along with the requested medication?

□ Other: ______________________________________

**Physician office's signature**

**Print Name**

*Form must be completed and signed by physician or licensed representative from the physician’s office*