Jefferson Health Plans

PRIOR AUTHORIZATION REQUEST FORM
Individual and Family Plans

Icatibant

Fax back to: (833) 605-4407
Phone: (215) 991-4300

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	**Prescriber Name:**
Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Line of Business: □ Exchange - PA	NPI: State Lic ID:
Address:	Address:
City, State ZIP:	City, State ZIP:
Primary Phone:	**Specialty/facility name (if applicable):**

☐ REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Drug Name:	
Strength:	
Directions / SIG:	

Please attach any pertinent medical history including labs and information for this member that may support approval.
Please answer the following questions and sign.

Q1. Is this an initial or continuation request?

☐ Initial - Go to 2 ☐ Continuation - Go to 9

Q2. Does the patient have a documented diagnosis of hereditary angioedema (HAE)?

☐ Yes ☐ No

Q3. Is there confirmation that Icatibant is being used for the treatment of acute hereditary angioedema (HAE) attacks?

☐ Yes ☐ No

Q4. Is the patient 18 years of age or older?

☐ Yes ☐ No

Q5. Is the patient prescribed other drugs indicated for acute treatment of hereditary angioedema?

☐ Yes ☐ No

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Patient Name:	**Prescriber Name:**

Q6. Is icatibant being the prescribed by or in consultation with an allergist, immunologist pulmologist or prescriber who specializes in the management of HAE?

☐ Yes ☐ No

Q7. Is this a request for a formulary product?

☐ Yes ☐ No

Q8. Is there documentation of an inadequate response, intolerance, or contraindication to all formulary products indicated for the diagnosis that would not be expected to occur with requested agent?

☐ Yes ☐ No

Q9. For continuation, is there documentation of reduction in severity or duration of attacks?

☐ Yes ☐ No

Q10. Additional Information:

_____ _____

Prescriber Signature Date

v2026

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