### Hereditary Angioedema

**Assessment**

1. **Primary Coverage**
   - (None)

2. **Medication Request**
   - 1. Medication Requested: (None)
   - 2. Drug Name: (None)
   - 3. Dosage Form (e.g., IV, SC, oral):
   - 4. Dose Regimen, including strength (e.g., 1000 units every 3-4 days):

3. **Request Information**
   - 1. Office Fax Number:
   - 2. You may ask for expedited timeframe, if the standard timeframe for response could seriously jeopardize patient life, health, or the ability to recover. If you are requesting an expedited (urgent) review, provide justification:

4. **Medical Condition Assessment**
   - 1. Patient MRN #:
   - 2. Diagnosis and Date of Diagnosis:
   - 3. Does patient have recurrent laryngeal edema? (None)
   - 4. Does patient have self-limiting, non-inflammatory subcutaneous angioedema? (None)
   - 5. If yes to question 4, does patient have urticaria? (None)
   - 6. If yes to question 4, is angioedema recurrent? (None)
   - 7. If yes to question 4, how long does angioedema last? (Hours)
   - 8. Does patient have self-resolving abdominal pain? (None)

5. **Purpose of Requested Medication**
   - (None)

6. **Type of Request**
   - (None)

7. **First (or next) scheduled dose (approximate date):**

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**Notes:**

- *(Dates and other information)*

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**Date:** 10/19/15
9. If yes to question 8, does pain have a clear organic etiology? (None)

10. If yes to question 8, is pain recurrent? (None)

11. If yes to question 8, how long does pain last? (hours)

12. How many attacks per month does the patient have?

13. Has patient experienced symptoms of MODERATE to SEVERE attack (e.g. airway swelling, severe abdominal pain, facial swelling, laryngeal swelling, nausea and vomiting, painful facial distortion)?


FOR NEW START REQUESTS, OR PATIENTS NEW TO HAP, COMPLETE THIS SECTION:

1. Provide patient’s C4 level and Date(s) (mg/dl)

2. Provide patient’s C1 inhibitor antigenic level and Date(s) (mg/dl)

3. Provide patient’s C1 inhibitor functional level and Date(s) (%)

4. Does patient have a known hereditary angioedema-causing C1 inhibitor mutation? Please explain:

FOR CONTINUATION REQUESTS COMPLETE THIS SECTION:

1. How long has the patient been receiving the requested medication (e.g. taken since May 2012)?

2. For Cinryze: Patient’s response to therapy (select all that apply):
   - Reduction in number of attacks per month
   - Reduction in severity of attacks
   - Reduction in duration of attacks
   - Other

3. If selected “Other” above, please describe:

4. Please document any additional information:

5. If the patient has NOT had an appropriate response as listed above, please provide rationale for continued therapy (required):

MEDICATION HISTORY

1. List all past and present medications used to treat this condition and reasons for discontinuation (Provide Medication Name, Dose, Dates of Therapy and Reason for D/C):

2. Continued List of Medications (If needed):

3. Is the patient using Danazol for prophylaxis? If Yes, what is their dose and length of therapy? If No, why not?

4. Is patient taking any of the following medications known to cause or exacerbate angioedema? (Select all that apply)
   - Estrogens (ex. Premarin, Estrace, estradiol)
   - ACE-inhibitors (ex. Lisinopril, Zestril, ramipril)
   - ARBS (angiotensin II receptor blockers) (ex. Losartan, irbesartan, Diovan)

5. If any medication selected in question 4 please explain why patient has NOT discontinued taking the medication that can cause or exacerbate angioedema:
1. Is the following REQUIRED documentation included? Relevant medical records - labs (when applicable) - other pertinent result.

(\(\text{None}\))

2. Please indicate how you will supply the supporting documentation.

(\(\text{None}\))

3. I certify that the above information is true and accurate and supported by medical records.

(\(\text{None}\))

4. Please enter your - Name:

5. Please enter your - Position:

6. Please enter your - Phone number:

Complete  Cancel