USFHP Prior Authorization Request Form for lanadelumab **(Takhzyro),** berotralstat hydrochloride **(Orladeyo)**

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD.

The completed form may be faxed to 855-273-5735

OR

The patient may attach the completed form to the prescription and **mail** it to:

Attn: Pharmacy, 77 Warren St, Brighton, MA 02135

QUESTIONS? Call 1-877-880-7007

https://www.usfamilyhealth.org/for-providers/pharmacy-information/

Step 1 **Please complete patient and physician information** (please print):

Patient Name:		Physician Name:	
Address:		Address:	
Sponsor ID #		Phone #:	
Date of Birth:		Secure Fax #:	

Step 2 **Please complete the clinical assessment:**

1. What drug is being requested?	☐ Takhzyro – Proceed to question **2** ☐ Orladeyo – Proceed to question **3**	
2. Is the patient greater than or equal to 2 years of age?	☐ Yes Proceed to question **4**	☐ No **STOP** Coverage not approved
3. Is the patient greater than or equal to 12 years of age?	☐ Yes Proceed to question **4**	☐ No **STOP** Coverage not approved
4. Does the patient have a diagnosis of hereditary angioedema (HAE)?	☐ Yes Proceed to question **5**	☐ No **STOP** Coverage not approved
5. Is the requested medication being prescribed by an allergist, immunologist, or rheumatologist, or in consultation with an HAE specialist?	☐ Yes Proceed to question **6**	☐ No **STOP** Coverage not approved
6. Does the patient have monthly HAE attacks or a history of severe attacks that require prophylaxis treatment (for example, GREATER THAN OR EQUAL TO 2 HAE attacks per month, laryngeal attacks, etc.)?	☐ Yes Proceed to question **7**	☐ No **STOP** Coverage not approved
7. Is the patient currently receiving another drug for HAE prophylaxis (for example, Orladeyo, Takhzyro, Cinryze or Haegarda will be used concomitantly)?	☐ Yes **STOP** Coverage not approved	☐ No **Sign and date below**

Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date:

Prescriber Signature _____ Date _____

[27 September 2023]