



Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.
Takhzyro (lanadelumab-flyo) Prior Authorization (PA)
Pharmacy Benefits Prior Authorization Help Desk
Length of Authorizations: Initial- 6 months; Continuation- 12 months

Instructions:

This form is used by Kaiser Permanente and/or participating providers for coverage of **Takhzyro (lanadelumab-flyo)** for **Commercial, Exchange, FEHB (Federal), and MD Medicaid** plans. Please complete all sections, incomplete forms will delay processing. Fax this form back to Kaiser Permanente within 24 hours (fax: 1-866-331-2104). If you have any questions or concerns, please call 1-866-331-2103. **Requests will not be considered unless all sections are complete.** KP-MAS Formulary can be found at: [Pharmacy | Community Provider Portal | Kaiser Permanente](#)

1 – Patient Information

Patient Name: _____ Kaiser Medical ID#: _____ Date of Birth: _____

2 – Prescriber Information

Prescriber Name: _____ Specialty: _____ NPI: _____

Prescriber Address: _____

Prescriber Phone #: _____ Prescriber Fax #: _____

Do you have an approved provider referral number from Kaiser Permanente?

☐ Yes – please provide your provider referral number here: _____

3 – Pharmacy Information

Pharmacy Name: _____ Pharmacy NPI: _____

Pharmacy Phone # _____ Pharmacy Fax #: _____

4 – Drug Therapy Requested

Drug 1: Name/Strength/Formulation: _____

Sig: _____

Drug 2: Name/Strength/Formulation: _____

Sig: _____

5– Diagnosis/Clinical Criteria

1. Is this request for initial or continuing therapy?
☐ Initial therapy ☐ Continuing therapy, state start date: _____
2. Indicate the patient's diagnosis for the requested medication: _____

Clinical Criteria:

1. Is the prescriber an Allergist, Immunologist, or Physician specializing in the treatment of hereditary angioedema (HAE)?
☐ No ☐ Yes
2. Is the patient ≥ 2 years of age?
☐ No ☐ Yes
3. Does the patient have a diagnosis of HAE type I or type II as confirmed by ONE of the following?
 - Mutation known to cause HAE in either the SERPING1 or F12 gene, OR
 - A C4 level below the lower limit of normal and/or a C1 inhibitor (C1-INH) antigenic level or functional level below the lower limit of normal☐ No ☐ Yes
4. Does provider attest that Takhzyro is NOT being used in combination with other products indicated for prophylaxis against HAE attacks?
☐ No ☐ Yes

For continuation of therapy, please respond to additional questions below. New members who were initiated on therapy outside of Kaiser, who have not been reviewed previously, must meet all above Clinical Criteria.

1. Has specialist follow-up occurred in the past 12 months with documented improvement while on Takhzyro?
☐ No ☐ Yes
2. Does provider attest that Takhzyro is NOT being used in combination with other products indicated for prophylaxis against HAE attacks?
☐ No ☐ Yes
3. If patient has been stable (i.e. attack free) for >6 months: Is there documentation that extending the dosing interval to 300 mg every 4 weeks has been considered, OR is patient's current dosing already 300 mg every 4 weeks?
☐ No ☐ Yes

6 – Prescriber Sign-Off

Additional Information –

1. **Please submit chart notes/medical records for the patient that are applicable to this request.**
2. **If member has not tried preferred agent(s) please provide rationale/explanation and any additional supporting information that should be taken into consideration for the requested medication:**

I certify that the information provided is accurate. Supporting documentation is available for State audits.

Prescriber Signature:

Date:

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