



Send completed form to:
Peach State Health Plan Pharmacy Department
Fax: 1-866-374-1579

Berinert

Prior Authorization Request

This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form toll-free to Peach State Health Plan at 1-866-374-1579.** If you have questions regarding the prior authorization, eligibility, drug copy or medication delivery; please contact Peach State Health Plan at **1-800-514-0083 option # 2.**

Patient Name: _____ **Date:** _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____
Physician Office Address: _____

1. What drug is being prescribed?
 Berinert Dose: _____ Frequency: _____ Weight: _____ kg OR _____ lbs
 Other _____
2. Does prescribed Berinert dose exceed 20 units/kg? Yes No
3. What is the diagnosis? Hereditary Angioedema (HAE) Other _____
4. What is the ICD-9 Code? _____
5. Has HAE confirmed by decreased serum levels of C4 AND absence or marked decrease (less than 50% of normal) of the level or function of C1-INH (C1-esterase inhibitor)? Yes No
6. What is the patient's age? _____ years
7. Will Berinert be used for treatment of acute abdominal attacks or facial swelling associated with HAE?
 Yes No

****NOTE: We can NOT make a decision without documentation - Thank You****

Information given on this form is accurate as of this date:

X _____
Prescriber or Authorized Signature **Date (mm/dd/yy)**

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