



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

## Kalbitor

### 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?  
 Kalbitor, Dose: \_\_\_\_\_ Frequency: \_\_\_\_\_  Other \_\_\_\_\_
2. What is the diagnosis?  Hereditary Angioedema (HAE)  Other \_\_\_\_\_
3. What is the ICD-9 Code? \_\_\_\_\_
4. 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
5. What is the patient's age? \_\_\_\_\_ years
6. Will Kalbitor be used for treatment of acute HAE attack?  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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