

**Complete Patient and Physician information (PLEASE PRINT)**

STEP  
1

|              |                       |
|--------------|-----------------------|
| Member Name: | Physician Name:       |
| Address:     | Address:              |
| Member ID:   | Phone #:              |
| Member DOB:  | Fax #:                |
|              | Tax ID or NPI Number: |

If Applicable: Pharmacy Name: \_\_\_\_\_  
Pharmacy Phone: \_\_\_\_\_

**Complete the Clinical Assessment:**

STEP  
2

|                          |  |
|--------------------------|--|
| Diagnosis                | <input type="checkbox"/> Hereditary Angioedema (HAE) <input type="checkbox"/> Other (please state): _____<br>_____   |
| Clinical Consideration   | <input type="checkbox"/> Use in <u>acute</u> attack of HAE in persons 16 years of age or older experiencing at least one symptom of a moderate or severe attack (i.e. sudden swelling of different parts of the body, airway swelling, abdominal cramping, painful facial distortion).<br><input type="checkbox"/> Documentation must include:<br>-evidence of a normal C1 level and a low C4 level plus a low C1 inhibitor antigenic level;<br><b>or</b><br>-evidence of a normal C1 inhibitor antigenic level and a low C1 inhibitor functional level.<br><input type="checkbox"/> Will be administered by a healthcare professional with appropriate medical support available to manage anaphylaxis and HAE. |
| Physician Specialty      | Diagnosis made by:<br><input type="checkbox"/> HAE knowledgeable physician <input type="checkbox"/> Other (please state): _____  |
| Supporting Documentation | Diagnosis: ICD-9/10 Code #/ Description / J Code (required): _____   |
|                          | Please attach a copy of the prescription or provide ALL of the information below:<br>Kalbitor® (escallantide)<br>Strength _____<br>Sig _____<br>Qty _____<br>Refills _____   |
|                          | <p style="text-align: center;"><i>*Please attach all relevant medical records and test results*</i></p> <p style="text-align: center;"><b>We will not process incomplete forms.</b></p> <p style="text-align: center;"><b>If we do not receive the completed form &amp; all relevant medical records &amp; test results within 10 calendar days of this request, it will be denied.</b></p>  |

STEP  
3

I certify that the above is correct and accurate to the best of my knowledge and that the form is complete.  
(please sign and date)

\_\_\_\_\_  
Prescriber Signature

\_\_\_\_\_  
Date

STEP  
4

**Fax completed form to the Rocky Mountain Health Plans Pharmacy Help Desk: 970-248-5034**

Name of Person filling out form: \_\_\_\_\_

Pharmacy Technician initials \_\_\_\_\_ Date Initiated \_\_\_\_\_

**Confidentiality Notice:**

This facsimile transmission (and/or documents accompanying it) may contain confidential information. This information is intended only for the use of the individual(s) named above. If you have received this transmission in error, or cannot identify the recipient for distribution purposes, please notify us immediately at 970-244-7760. Plans underwritten by Rocky Mountain HMO or Rocky Mountain HealthCare Options. 07/28/11