pennsylvania
DEPARTMENT OF HUMAN SERVICES

Office of Medical Assistance Programs
Fee-for-Service, Pharmacy Division
Phone 1-800-537-8862 Fax 1-866-327-0191

HEREDITARY ANGIOEDEMA AGENTS PRIOR AUTHORIZATION FORM

Prior authorization guidelines for **Hereditary Angioedema (HAE) agents** and **Quantity Limits/Daily Dose Limits** are available on the DHS Pharmacy Services website at http://www.dhs.pa.gov/provider/pharmacyservices/index.htm.

PRIOR AUTHORIZATION INFORMATION		PRESCRIBER INFORMATION	
☐New request ☐Renewal request	# of pages: _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		State license #:	
LTC facility contact/phone:		NPI:	MA Provider ID#:
BENEFICIARY INFORMATION		Street address:	
Beneficiary Name:		Suite #:	City/state/zip:
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Medication requested: (all agents in this class require prior authorization)	**C1 inhibitor (human)**	**C1 inhibitor (recombinant)**	**bradykinin inhibitor**	**kallikrein inhibitor**
	☐Berinert (preferred) [specialty] ☐Cinryze (non-preferred) ☐Haegarda (preferred) [specialty]	☐Ruconest (non-preferred) [specialty]	☐Firazyr (preferred) [specialty]	☐Kalbitor (non-preferred)

Strength:	Dose/directions:	Quantity:	Refills:

Diagnoses (*submit documentation*):	Dx codes (*required*):
The agents indicated above with **[specialty]** are part of the Department's Specialty Pharmacy Drug Program (SPDP). Which Specialty Pharmacy will be used?	☐Diplomat Specialty Pharmacy ☐Walgreen's Specialty Pharmacy

INITIAL requests

1. Has the Beneficiary been diagnosed with hereditary angioedema (HAE) by an allergist or immunologist as evidenced by both of the following? *Check all that apply and* ***submit documentation of requested lab results.***
   ☐low C4 complement level (mg/dL) ☐low C1 esterase inhibitor antigenic level (mg/dL) or functional level (< 65%)
2. Is the Beneficiary taking either of the following? *Check all that apply and* ***submit documentation of Beneficiary's medication list.***
   ☐estrogen-containing agent (hormone replacement, contraceptives, etc.) ☐ACE inhibitor (lisinopril, enalapril, ramipril, etc.)
3. *If the requested agent is a* ***C1 inhibitor (human)*** *[indicated in the above list]*, does the Beneficiary have documentation of all of the following? *Check all that apply and* ***submit supporting documentation, including lab results.***
   ☐tested for hepatitis B ☐vaccinated for hepatitis B ☐tested for hepatitis C ☐tested for HIV

4. *If the requested agent is a* ***C1 inhibitor*** *being used for the* ***prophylaxis*** *of HAE*, does the Beneficiary have a history of more than one HAE attack per month that required acute treatment in the hospital emergency department setting?	☐Yes ☐No *Submit supporting documentation.*
5. *If the request is for a* ***non-preferred*** *agent (indicated as non-preferred in the above list)*, does the Beneficiary have a history of trial and failure, contraindication, or intolerance of the preferred agents? *Check all that apply.* ☐Berinert (C1 inhibitor) ☐Haegarda (C1 inhibitor) ☐Firazyr (icatibant)	☐Yes ☐No *Submit supporting documentation.*
6. *If the request is for a* ***non-preferred*** *agent*, does the Beneficiary have a current prescription (within the past 90 days) for the requested agent?	☐Yes ☐No *Submit supporting documentation.*

RENEWAL requests

1. Is the requested agent prescribed by an allergist or immunologist?	☐Yes ☐No
2. *If the requested agent is a* ***C1 inhibitor (human)*** *[indicated in the above list]*, has the Beneficiary been tested annually for all of the following? *Check all that apply and* ***submit documentation of test results.*** ☐hepatitis B ☐hepatitis C ☐HIV	
3. *If the requested agent is a* ***C1 inhibitor*** *being used for the* ***prophylaxis*** *of HAE*, has the Beneficiary experienced a reduction in the number and/or severity of HAE attacks?	☐Yes ☐No *Submit documentation of Beneficiary's response to therapy.*

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

Prescriber Signature:	**Date**: