

HEREDITARY ANGIOEDEMA AGENTS PRIOR AUTHORIZATION FORM

- Prior authorization guidelines and quantity limits may be found in the Medical Assistance Prior Authorization of Pharmaceutical Services Handbook Chapters – **Hereditary Angioedema (HAE) agents** and **Quantity Limits/Daily Dose Limits**, accessible on the Department's Pharmacy Services website at <http://www.dhs.pa.gov/provider/pharmacyservices/index.htm>.

PRIOR AUTHORIZATION INFORMATION		PRESCRIBER INFORMATION	
<input type="checkbox"/> New request	<input type="checkbox"/> Additional info	# of pages in request: _____	
<input type="checkbox"/> Renewal request	PA# _____	Prescriber name: _____	
Name of office contact: _____		Specialty: _____	
Contact's phone number: _____		State license #: _____	
LTC facility contact/phone: _____	NPI: _____	MA Provider ID#: _____	
RECIPIENT INFORMATION		Street address: _____	
Recipient Name: _____		Suite #: _____	City/state/zip: _____
Recipient ID#: _____	DOB: _____	Phone: _____	Fax: _____

CLINICAL INFORMATION

Medication requested: (all agents in this class require prior authorization)	C1 inhibitor (human) <input type="checkbox"/> Berinert (preferred) [specialty] <input type="checkbox"/> Cinryze (non-preferred)	C1 inhibitor (recombinant) <input type="checkbox"/> Ruconest (non-preferred) [specialty]	bradykinin inhibitor <input type="checkbox"/> Firazyr (preferred) [specialty]	kallikrein inhibitor <input type="checkbox"/> Kalbitor (non-preferred)
Strength: _____	Dose/directions: _____		Quantity: _____	Refills: _____
Diagnoses (<i>submit documentation</i>): _____			Dx codes (<i>required</i>): _____	
The agents indicated above with [specialty] are part of the Department's Specialty Pharmacy Drug Program (SPDP). What Specialty Pharmacy will be used?			<input type="checkbox"/> Diplomat Specialty Pharmacy <input type="checkbox"/> Walgreens Specialty Pharmacy	

Section A: INITIAL requests

- Has the Recipient 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%)
- Is the Recipient taking, or will be taking, either of the following? *Check all that apply and submit documentation of Recipient's medication list.*
 estrogen-containing agent (hormone replacement, contraceptives, etc.) ACE inhibitor (lisinopril, enalapril, ramipril, etc.)
- If the requested agent is a C1 inhibitor (human) [indicated in the above list],* does the Recipient 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
- If the requested agent is a C1 inhibitor being used for the prophylaxis of HAE,* does the Recipient 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.*
- If the request is for a non-preferred agent (indicated as non-preferred in the above list),* does the Recipient have a history of trial and failure, contraindication, or intolerance of the preferred agents? *Check all that apply.*
 Berinert (C1 inhibitor) Firazyr (icatibant)
 Yes No *Submit supporting documentation.*
- If the request is for a non-preferred agent,* does the Recipient have a current prescription (within the past 90 days) for the requested agent?
 Yes No *Submit supporting documentation.*

Section B: RENEWAL requests

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

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

Prescriber Signature: _____	Date: _____
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