

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 <https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/default.aspx>.

<input type="checkbox"/> New request <input type="checkbox"/> Renewal request		# of pages: _____	Prescriber name:	
Name of office contact:			Specialty:	
Contact's phone number:		NPI:	State license #:	
LTC facility contact/phone:		Street address:		
Beneficiary name:		Suite #:	City/state/zip:	
Beneficiary ID#:	DOB:	Phone:	Fax:	

CLINICAL INFORMATION

Drug requested:		Strength:	
Dose/directions:		Quantity:	Refills:
Diagnoses (<i>submit documentation</i>):		Dx codes (<i>required</i>):	
Has the beneficiary been taking the requested medication within the past 90 days?		<input type="checkbox"/> Yes <i>Submit documentation of drug regimen and clinical response.</i> <input type="checkbox"/> No	
Is the requested agent prescribed by an allergist or immunologist?		<input type="checkbox"/> Yes <input type="checkbox"/> No	

INITIAL requests

Complete the sections below that are applicable to the beneficiary and this request and SUBMIT DOCUMENTATION for each item.

INITIAL requests:

- Has a low C4 complement level
- Has a low C1 esterase inhibitor antigenic level OR functional level
- Is NOT taking an estrogen-containing agent (hormone replacement, contraceptives, etc.)
- Is NOT taking an ACE inhibitor (lisinopril, enalapril, ramipril, etc.)
- Human C1 inhibitor requests (e.g., Berinert, Cinryze, Haegarda):**
 - Was tested for hepatitis B virus infection
 - Was tested for hepatitis C virus infection
 - Was testing for HIV infection
 - Was vaccinated against hepatitis B virus
- For a C1 esterase inhibitor for prophylaxis (e.g., Cinryze, Haegarda, Ruconest):**
 - Has a history of 1 or more HAE attacks per month that require acute treatment in the hospital emergency department
- For a non-preferred HAE Agent:**
 - Has a history of trial and failure of or contraindication or intolerance to the preferred agents in this class that are approved or medically accepted for treatment of the beneficiary's condition? Refer to <https://papdl.com/preferred-drug-list> for a list of preferred and non-preferred agents in this class.

RENEWAL requests:

- Human C1 inhibitor requests (e.g., Berinert, Cinryze, Haegarda):**
 - Is being tested annually for hepatitis B virus infection
 - Is being tested annually for hepatitis C virus infection
 - Is being tested annually for HIV infection
- For a C1 esterase inhibitor for prophylaxis (e.g., Cinryze, Haegarda, Ruconest):**
 - Experienced fewer or less severe HAE attacks since starting the requested medication

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

Prescriber Signature:	Date:
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