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 (*form effective 01/05/2021*)

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.

☐New request ☐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 (*submit documentation*):	Dx codes (*required*):	
Has the beneficiary been taking the requested medication within the past 90 days?	☐Yes ☐No	*Submit documentation of drug regimen and clinical response.*
Is the requested agent prescribed by or in consultation with an allergist/immunologist, dermatologist, or hematologist?	☐Yes ☐No	*Submit documentation of consultation, if applicable.*
Will the beneficiary be using the requested medication with any other HAE Agents?	☐Yes – please list: _____ ☐No	

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

INITIAL requests

☐Requested medication is being used for short-term prophylaxis (e.g., surgical or dental procedure)
☐Has a diagnosis of HAE Type I or Type II (with C1 inhibitor deficiency/dysfunction)
- ☐Has a low C4 complement level obtained on 2 separate occasions
- ☐Has a low C1 esterase inhibitor antigenic level OR functional level (<65% [unless already using an androgen or C1 esterase inhibitor])

☐Has a diagnosis of HAE Type III (with normal C1 inhibitor)
- ☐Has a normal C4 complement level (mg/dL)
- ☐Has a normal C1 esterase inhibitor antigenic level (mg/dL)
- ☐Has a normal C1 esterase inhibitor functional level
- ☐Has a history of recurrent angioedema without urticaria
- ☐Has a family history of HAE --OR-- ☐Has an HAE-causing genetic mutation
- ☐Failed to respond to maximum recommended doses of antihistamines (e.g., cetirizine 20 mg twice daily)

☐Is taking an estrogen-containing agent (hormone replacement, contraceptives, etc.) – specify indication: _____
☐Is taking an ACE inhibitor (lisinopril, enalapril, ramipril, etc.)
☐Is using the requested medication for long-term prophylaxis
- ☐Has poorly controlled HAE despite use of an HAE Agent for on demand/acute treatment

☐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

☐Is using the requested medication for long-term prophylaxis and experienced fewer HAE attacks since starting the requested medication
☐Is using the requested medication for acute treatment and experienced a positive clinical response to the requested medication

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

Prescriber Signature:	Date: