HEALTHY U MEDICAID

PRIOR AUTHORIZATION REQUEST FORM

HEREDITARY ANGIOEDEMA AGENTS

Berinert®, Cinryze®, icatibant, Firazyr®, Haegarda®, Kalbitor®, Takhzyro®

For authorization, please answer each question and fax this form PLUS chart notes back to the Healthy U Prior Authorization Department at 385-425-4052.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance: 385-425-5094

Disclaimer: Prior Authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Preferred: ☐ Berinert®(C1 esterase inhibitor [human])*, ☐ Haegarda® (C1 esterase inhibitor [human]), ☐ icatibant
Non-preferred: : ☐ Cinryze® (C1 esterase inhibitor subcutaneous [human]) ☐ Firazyr® (icatibant), ☐ Kalbitor® (ecallantide), ☐ Takhzyro® (lanadelumab)

*preferred for specified populations. Refer to medication use policy.

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section

Questions	Yes	No	Comments/Notes
1. Is the request for treatment of Hereditary Angioedema (HAE)?	☐	☐	
2. Is the requesting provider a board-certified immunologist or allergist?	☐	☐	
3. Does the member have clinical presentations consistent with a HAE subtype (HAE I, HAE II, or HAE with normal C1INH) confirmed by repeat blood testing?	☐	☐	**Please provide documentation**
4. Has the member's diagnosis of Hereditary Angioedema been confirmed with complement 4 (C4) protein and C1-inhibitor levels?	☐	☐	**Please provide documentation**
5. Has the member had a trial and failure of each of the following: antihistamines, glucocorticoids, and epinephrine?	☐	☐	**Please provide documentation**
6. Is the member currently taking ACE-inhibitors or estrogen-containing oral medications?	☐	☐	
7. Has the member's attack frequency, severity, and location been documented?	☐	☐	**Please provide documentation**

8. Is the member/caregiver able and ready to administer medication at home?	☐	☐	
9. For acute HAE attack treatment: Does the member have a history of at least one attack per year?	☐	☐	**Please provide documentation**
10. For long-term prophylaxis of HAE attacks: Does the member have a history of two acute severe attacks per month or at least 5 attacks of moderate severity per month on average?	☐	☐	**Please provide documentation**
11. For long-term prophylaxis of HAE attacks: Has the member tried and failed, or have a contraindication to, danazol therapy?	☐	☐	**Please provide documentation**
12. For long-term prophylaxis of HAE attacks: Does laboratory test show the member has not experienced HAE attacks due to preventable triggers, such as helicobacter pylori infections in members with gastrointestinal attacks?	☐	☐	**Please provide documentation**
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Has the member experienced unacceptable toxicity (e.g. hypersensitivity reactions, serious thrombotic events, significantly elevated hepatic serum transaminases) to the drug?	☐	☐	
3. For acute HAE attack treatment: Does documentation show that the member continues to experience at least one acute HAE attack per year AND is the request for a refill due to a documented attack OR has the medication on hand reached the expiration date?	☐	☐	**Please provide documentation**
4. For long-term prophylaxis of HAE attacks: Has the provider evaluated the member's need for long-term prophylaxis at least once per year?	☐	☐	
5. For long-term prophylaxis of HAE attacks: Has the member had significant improvements in severity and duration of attacks compared to baseline?	☐	☐	**Please provide documentation**
What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.			
Additional information:			
Physician's Signature:			

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Policy PHARM-HU-031
Origination Date: 01/01/2022
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