

HEREDITARY ANGIOEDEMA AGENTS PRIOR AUTHORIZATION FORM *(form effective 7/15/2024)*

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.pa.gov/en/agencies/dhs/resources/for-providers/ma-for-providers/pharmacy-services.html>.

<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:			City/state/zip:	
Beneficiary ID#:	DOB:	Phone:	Fax:	

CLINICAL INFORMATION

Drug requested:	Strength:	Dosage form:	
Dose/directions:		Quantity:	Refills:
Diagnoses <i>(submit documentation)</i> :		Dx codes <i>(required)</i> :	
What is the beneficiary's weight?		_____ kg / lbs	
Has the beneficiary been taking the requested medication within the past 90 days?		<input type="checkbox"/> Yes <i>Submit documentation and date of last dose.</i> <input type="checkbox"/> No	
Is the requested medication prescribed by or in consultation with an allergist/immunologist, dermatologist, or hematologist?		<input type="checkbox"/> Yes <i>Submit documentation of consultation, if applicable.</i> <input type="checkbox"/> No	
Will the beneficiary be using the requested medication with any other HAE Agents for the same indication (ie, more than 1 HAE Agent for <u>acute treatment</u> OR more than 1 HAE Agent for <u>long-term prophylaxis</u>)?		<input type="checkbox"/> Yes – please list: _____ _____ <input type="checkbox"/> No	

**Complete all sections that apply to the beneficiary and this request.
Check all that apply and submit documentation for each item.**

INITIAL requests

<input type="checkbox"/> Requested medication is being used for short-term prophylaxis (e.g., surgical or dental procedure) <input type="checkbox"/> Has a diagnosis of HAE Type I or Type II (with C1 inhibitor deficiency/dysfunction) AND:

- Has a low C4 complement level (mg/dL) obtained on 2 separate occasions
- At least one of the following:
 - Has a low C1 esterase inhibitor antigenic level (mg/dL) obtained on 2 separate occasions
 - Has a low C1 esterase inhibitor functional level (<65% [unless already using an androgen or C1 esterase inhibitor]) obtained on 2 separate occasions
- Has a diagnosis of **HAE Type III** (with normal C1 inhibitor) AND:
 - 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
 - One of the following:
 - Both of the following:
 - Has a family history of HAE
 - Failed to respond to maximum recommended doses of antihistamines (eg, cetirizine 20 mg twice daily)
 - Has an HAE-causing genetic mutation
- One of the following:
 - Is not taking an estrogen-containing medication (hormone replacement, contraceptives, etc.)
 - Is taking an estrogen-containing medication (hormone replacement, contraceptives, etc.) that is medically necessary for the beneficiary's indication – specify indication: _____
- Is not taking an ACE inhibitor (benazepril, enalapril, lisinopril, quinapril, ramipril, etc.)
- Is using the requested medication for **long-term prophylaxis** AND:
 - 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:

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