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 1/8/2024*)

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

CLINICAL INFORMATION

Drug requested:	Strength:	Dosage form:	
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 and date of last dose.*
Is the requested medication 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 for the same indication (ie, more than 1 HAE Agent for acute treatment OR more than 1 HAE Agent for long-term prophylaxis)?		☐Yes – please list: _____ _____ ☐No	

Complete all sections that apply to the beneficiary and this request.
Check all that apply 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) AND:

- ☐Has a low C4 complement level (mg/dL) obtained on 2 separate occasions
- ☐At least one of the following:

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- ☐ 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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