HERITAGE HEALTH | nebraska total care

# Nebraska Medicaid Program Request for Prior Authorization of Payment
## Hereditary Angioedema (HAE)

**If the following information is not complete, correct, or legible, the PA process can be delayed.** *Please use one form per member.*

***Member Information***

**LAST NAME:** __________ **FIRST NAME:** __________

**MEDICAID NUMBER:** __________ **DATE OF BIRTH:** ____ – ____ – ____

***Prescriber Information***

**LAST NAME:** __________ **FIRST NAME:** __________

**NPI NUMBER:** __________ **DEA NUMBER:** __________

**PHONE NUMBER:** ____ – ____ – ____ **FAX NUMBER:** ____ – ____ – ____

***Participating Pharmacy***

**NAME:** __________ **REQUEST DATE** __________

**PHONE NUMBER:** ____ – ____ – ____ **FAX NUMBER:** ____ – ____ – ____

**Please indicate which medication is being requested and complete the information below:**

**Preferred:**
- ☐ Berinert
- ☐ Firazyr
- ☐ Haegarda

**Non-preferred:**
- ☐ Cinryze
- ☐ icatibant acetate
- ☐ Kalbitor
- ☐ Ruconest
- ☐ Takhzyro
- ☐ Other: __________

Strength: __________ Dosing schedule: __________ Quantity per month: __________

For current PDL status, please visit: https://nebraska.fhsc.com/downloads/PDL/NE_PDL.pdf

1. Indicate reason for request: ☐ Angioedema prophylaxis treatment ☐ Treatment of acute hereditary angioedema
2. For HAE treatment, indicate HAE type: ☐ Type I ☐ Type II
3. If the patient is being prescribed the requested medication for a different diagnosis than above, document here (include ICD-10 diagnosis code): __________
4. Is the patient currently treated with the requested medication? ☐ Yes ☐ No

   If yes, when was treatment with the requested medication started? __________
5. For initial authorization, provide current labs of one of the following:
   - ☐ C4 level below the lower limit normal defined by lab, or < 14 mg/dL
   - ☐ C1-INH antigenic level below the lower limit of normal defined by lab, or < 19 mg/dL
   - ☐ C1-INH functional level/percentage below the lower limit of normal defined by lab, or < 50%

(*Form continued on next page*)



Submit request to: Pharmacy Services Fax: 833-404-2254, Tel: 844-330-7852
**Submit prior authorization (PA) requests electronically** through our preferred solution **CoverMyMeds**
at CoverMyMeds.com/main/prior-authorization-forms/.

**The following questions apply to requests for prophylaxis agents (Haegarda, Takhzyro, and Cinryze):**

6. Does the patient have a history of two or more attacks monthly? ☐ Yes ☐ No

7. Will the requested medication be used for short term prophylaxis treatment (i.e., surgery, dental, or other medical procedures, etc.)? If so, provide details and date of event.

______________________________________________________________________

8. Has the patient had a trial and failure or contraindication to oral danazol? ☐ Yes ☐ No

9. Continuation or renewal of prophylactic therapy requires documentation of any or all of the following:
   - ☐ Achieve and maintain at least a 50% reduction in number of HAE attacks
   - ☐ Achieve and maintain at least a 30% reduction in number of HAE attacks
   - ☐ Achieve and maintain at least a 60% reduction in days of swelling

10. Does the prescriber verify that the patient is NOT concurrently taking ACE inhibitors, NSAIDs, and estrogen-containing products? ☐ Yes ☐ No
    If not, please explain:

______________________________________________________________________

______________________________________________________________________ ____________________

***Prescriber Signature (Required)*** ***Date***

*(By signing, the prescriber confirms that the above information is accurate and verifiable by patient records.)*