AmeriHealth Caritas North Carolina

Pharmacy Request for Prior Approval – Hereditary Angioedema (HAE) Treatment Agents

Beneficiary Information

1. Beneficiary Last Name: _____ 2. First Name: _____
3. Beneficiary ID #: _____ 4. Beneficiary Date of Birth: _____ 5. Beneficiary Gender: _____

Prescriber Information

6. Prescriber Name: _____ NPI #: _____
Mailing address: _____ City: _____ State: _____ ZIP: _____
7. Requester Contact Information: _____
Name: _____ Phone #: _____ Fax #: _____

Drug Information

8. Drug Name: _____ 9. Strength: _____ 10. Quantity Per 30 Days: _____
11. Length of Therapy: ___up to 30 days ___60 days ___90 days ___120 days ___180 days ___365 days ___Other: _____

Clinical Information

All Treatment Agents: (questions 1-3)

1. Does the beneficiary have a diagnosis of HAE I or II; AND Low C4 level (C4 below the lower limit of normal as defined by the laboratory performing the test)? Yes___ No___
2. Does the beneficiary have a diagnosis of HAE with normal C1-INH (formerly known as HAE III)? Yes___ No___
   2a. Does the patient have a known HAE-causing mutation (e.g., mutation of coagulation factor XII gene [F12 mutation], mutation in the angiopoietin-1 gene, mutation in the plasminogen gene, mutation in the kininogen 1 gene, mutation in the myoferlin gene, mutation in the heparan sulfate 3-O sulfotransferase 6 gene, etc.)? Yes___ No___
   2b. Does the patient have a family history of HAE? Yes___ No___
3. Will this treatment not be used in combination with, other approved treatments for acute HAE attacks (e.g., Berinert, Firazyr, Kalbitor and Ruconest)? Yes___ No___
4. Will it be prescribed by, or in consultation with, a specialist in: allergy, immunology, hematology, pulmonology, or medical genetics? Yes___ No___
5. In addition, for non-preferred products, has the beneficiary tried and failed or experienced an insufficient response to at least two preferred products for the same indication or have a clinical reason that preferred products cannot be tried?
   Yes___ No___ List:_____

Requests for Berinert:

6. Is the request for treatment of acute abdominal, facial, or laryngeal attacks of HAE? Yes___ No___

Requests for Firazyr:

7. Is the request for treatment of acute abdominal, facial, or laryngeal attacks of HAE? Yes___ No___
8. Is the beneficiary at least 18 years of age? Yes___ No___

Requests for Kalbitor:

9. Is the request for treatment of acute abdominal, facial, or laryngeal attacks of HAE? Yes___ No___
10. Is the beneficiary at least 12 years of age? Yes___ No___

Requests for Ruconest:

11. Is the request for treatment of acute abdominal or facial attacks of HAE? Yes___ No___

Renewal Criteria for ALL AGENTS:

12. Does the beneficiary continue to meet the initial criteria? Yes___ No___
13. Since starting the medication, has the beneficiary experienced significant improvement in severity and duration of attacks and has this improvement been sustained? Yes___ No___
14. Has the beneficiary experienced any unacceptable toxicity from the medication? Yes___ No___

Signature of Prescriber: _____ Date: _____

***Prescriber signature mandatory**

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Fax this form to: 1-877-234-4274, or call Pharmacy Prior Authorization: 1-866-885-1406