OKLAHOMA Health Care Authority

State of Oklahoma
SoonerCare

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Hereditary Angioedema (HAE) Medications Prior Authorization Form

Member Name:_____ ***Date of Birth:***_____ ***Member ID#:***_____

Drug Information

☐ ***Physician billing*** **(HCPCS code:**_____**)** ☐ ***Pharmacy billing*** **(NDC:**_____**)**

Dose:_____ ***Regimen:***_____ ***Start Date (or date of next dose):***_____

Billing Provider Information

Provider NPI:_____ ***Provider Name:***_____

Provider Phone:_____ ***Provider Fax:***_____

Prescriber Information

Prescriber NPI:_____ ***Prescriber Name:***_____

Prescriber Phone:_____ ***Prescriber Fax:***_____ ***Specialty:***_____

Criteria

For Initial Authorization:

1. Please indicate the diagnosis and information:
   - ☐ **Hereditary Angioedema (HAE)**
   - ☐ **Other:** _____
2. For weight-based dosing, please provide member's recent weight: _____(kg); Date taken: _____
3. For **prophylaxis of HAE** please provide the following:
   a. Is member currently taking an angiotensin converting enzyme (ACE) inhibitor or estrogen replacement therapy? Yes☐ No☐
   b. Based on HAE attack frequency, attack severity, comorbid conditions, and member's access to emergent treatment, has prescriber determined long-term prophylaxis is appropriate for the member? Yes☐ No☐
   c. Has member had a recent hospitalization for a severe episode of angioedema? Yes☐ No☐
      i. If yes, please provide details: _____
   d. Has member or caregiver been trained by a health care professional on proper storage and administration of the prescribed product? Yes☐ No☐
   e. For Cinryze® and Haegarda®, please provide a patient-specific, clinically significant reason why the member cannot use Orladeyo®: _____
   f. For Takhzyro, please provide a patient-specific, clinically significant reason why the member cannot use Cinryze®, Haegarda® and Orladeyo®: _____
   g. For Andembry® and Dawnzera™, please provide a patient-specific, clinically significant reason why the member cannot use Takhyzro®, Cinryze®, Haegarda® and Orladeyo®: _____

_____

Fax completed prior authorization request form to 888-601-8461 or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts. All requested data must be provided. Incomplete forms or forms without the chart notes will be returned. Pharmacy Coverage Guidelines are available at AetnaBetterHealth.com/Oklahoma.	CONFIDENTIALITY NOTICE *This document, including any attachments, contains information which is confidential or privileged. If you are not the intended recipient, be aware that any disclosure, copying, distribution, or use of the contents of this information is prohibited. If you have received this document in error, please notify the sender immediately by telephone to arrange for the return of the transmitted documents or to verify their destruction.*

Hereditary Angioedema (HAE) Medications Prior Authorization Form

Member Name: _____ ***Date of Birth:*** _____ ***Member ID#:*** _____

Criteria

For Initial Authorization *(continued)*:

4. For **<u>treatment of acute attacks of HAE</u>** please provide the following:
   a. How will the requested product be administered?
      ☐ Self-administration
         i. Has member or caregiver been trained by a health care professional on proper storage and administration of the prescribed product? Yes☐ No☐
      ☐ By a health care professional
   b. For Berinert® and Sajazir™, please provide a patient-specific, clinically significant reason why the member cannot use Firazyr®: _____
   c. For Ekterly®, Kalbitor®, and Ruconest®, please provide a patient-specific, clinically significant reason why the member cannot use Berinert®, Sajazir™ and Firazyr®: _____

_____

Additional Information: _____

_____

_____

_____

Prescriber Signature: _____ **Date:** _____

I certify that the indicated treatment is medically necessary and all information is true and correct to the best of my knowledge.
Please do not send in chart notes. Specific information will be requested if necessary. Failure to complete this form in full will result in processing delays.

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