Anthem HealthKeepers Plus
Offered by HealthKeepers, Inc.

Prior Authorization (PA) Form
HEREDITARY ANGIOEDEMA (HAE) MEDICATIONS

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 ID Number:

Date of Birth: ___ – ___ – ____

Gender: ☐ **Male** ☐ **Female**

Weight in Kilograms: _____

PRESCRIBER INFORMATION

Last Name:

First Name:

NPI Number:

Phone Number: ___ – ___ – ____

Fax Number: ___ – ___ – ____

DRUG INFORMATION

Preferred Medications (Quantity Limits):

☐ Cinryze™ – 20 vials per 34 days

☐ Berinert® – 4 vials per attack (plus 4 for emergency)

☐ Kalbitor® – 3 vials per attack (plus 3 for emergency)

Non-preferred Medications (Quantity Limits):

☐ Firazyr® – 1 dose per attack (plus 1 for emergency) ☐ **icatibant** 1 dose per attack (plus 1 for emergency)

☐ Haegarda® – 2,000 IU SDV kit (16 kits per 28 days) & 3,000 IU SDV kit (8 kits per 28 days)

☐ Ruconest® – 2 vials per attack (plus 2 for emergency) ☐ Takhzyro® – 2 vials per 28 days

Drug Name/Form: _____

Strength: _____

Dosing Frequency: _____

Length of Therapy: _____

Quantity per Day: _____

(Form continued on next page.)

AVAPEC-2302-19 December 2019

Member's Last Name:

Member's First Name:

DIAGNOSIS AND MEDICAL INFORMATION

Hereditary Angioedema (HAE) Medications – to receive an approval for these drugs, complete the following questions.

1. Was the medication prescribed by, or in consultation with, a specialist in allergy, immunology, hematology, pulmonology, or medical genetics?

   ☐ Yes ☐ No

   If Yes, document the physician's specialty.: _____

For prophylaxis use, do any of the following criteria apply to the member?

2. Does the prescriber attest that the diagnosis was confirmed by a C4 level below the lower limit of normal as defined defined by laboratory test and any of the following?:
   - C1 inhibitor (C1-INH) antigenic level below the lower limit of normal as defined by the laboratory performing the test; **OR**
   - C1-INH functional level below the lower limit of normal as defined by the laboratory performing the test; **OR**
   - Presence of a known HAE-causing C1-INH mutation.

   ☐ Yes ☐ No
3. Does the member have HAE attacks occur at least once monthly?

   ☐ Yes ☐ No
4. Is the member disabled at least 5 days per month?

   ☐ Yes ☐ No
5. Does the member have a history of attacks with airway compromise/hospitalization?

   ☐ Yes ☐ No
6. Does the prescriber attest that the treatment with "on demand" therapy (i.e., Kalbitor®, Firazyr®, Ruconest®, Berinert®) did not provide satisfactory control (i.e., treatment for acute attacks was unsuccessful)?

   ☐ Yes ☐ No
7. Does the prescriber attest to trial/failure, intolerance, or contraindication to attenuated (17 alpha-alkylated) androgens (i.e., danazol) for HAE prophylaxis?

   ☐ Yes ☐ No

   If yes, document details.: _____

   _____

Hereditary Angioedema (HAE) Medications

Member's Last Name:

Member's First Name:

List pharmaceutical agents attempted and outcome.:

_____

_____

Medical Necessity: Provide clinical evidence that the preferred agent(s) will not provide adequate benefit and/or provide clinical rationale for quantity exception requests.:

_____

_____

_____ _____

Prescriber Signature (Required) **Date**

By signature, the Physician confirms the above information is accurate and verifiable by member records.

Please include ALL requested information; Incomplete forms will delay the PA process.
Submission of documentation does NOT guarantee coverage.

The completed form may be **FAXED 1-844-512-7020**.