Pharmacy Prior Authorization

AETNA BETTER HEALTH NEW JERSEY (MEDICAID)

Hereditary Angioedema (Medicaid)

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Aetna Better Health New Jersey at **1-855-296-0323**.
When conditions are met, we will authorize the coverage of Hereditary Angioedema (Medicaid).
Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

Drug Name *(circle drug)*

Berinert (human C1 esterase inhibitor)
Cinryze (C1 esterase inhibitor)
Firazyr (icatibant)
Haegarda (C1 esterase inhibitor subcutaneous [human])
Ruconest (recombinant C1 esterase inhibitor)
Kalbitor (ecallantide)
Takhzyro (lanadelumab)

Other, specify drug _____

Quantity _____ Frequency _____ Strength _____

Route of administration _____ Expected length of therapy _____

Member information

Member name: _____
Member ID: _____
Member Group No.: _____
Member DOB: _____
Member phone: _____

Prescribing physician

Physician name: _____

Specialty: _____ NPI number: _____

Physician fax: _____ Physician phone: _____

Physician address: _____ City, state, zip: _____

Diagnosis:_____ **ICD Code:**_____

Circle the appropriate answer for each question.

1. Has this plan authorized this medication in the past for this member for the management of hereditary angioedema (i.e., previous authorization is on file under this plan)? Y N

   [If no, then skip to question 3.]

2. Is there documentation demonstrating disease state improvement (e.g., a decrease in the number, severity, and/or duration of acute hereditary angioedema attacks)? Y N

Note: documentation must be submitted.

[No further questions.]

3. Is the request for Firazyr for the treatment of documented acute attacks of angioedema induced from angiotensin-converting enzyme (ACE) inhibitors? Y N

   [If yes, skip to question 16.]

4. Is the medication requested for the management of hereditary angioedema? Y N

   [If no, then no further questions.]

5. Is the requested medication prescribed by an allergy and immunology specialist, hematologist, or dermatologist? Y N

   [If no, then no further questions.]

6. Does the member have a diagnosis of hereditary angioedema type I confirmed by laboratory values (low C4 level AND low C1-inhibitor antigenic level)? Y N

   Note: Laboratory documentation must be submitted.

   [If yes, skip to question 10.]

7. Does the member have a diagnosis of hereditary angioedema type II confirmed by laboratory values (low C4 level AND normal or elevated C1-inhibitor antigenic level AND low C1-inhibitor functional level)? Y N

   Note: Laboratory documentation must be submitted.

   [If yes, skip to question 10.]

8. Does the member have a diagnosis of hereditary angioedema type III confirmed by laboratory values (normal C4 level AND normal C1-inhibitor antigenic level AND normal C1-inhibitor functional level)? Y N

   Note: Laboratory documentation must be submitted.

   [If no, then no further questions.]

9. Does the member have any of the following: A) documentation of a family history of hereditary angioedema, B) a known hereditary angioedema (HAE)-causing mutation? Y N

   [If no, then no further questions.]

10. Does the member have a documented history of at least one symptom of a moderate to severe hereditary angioedema attack (e.g., moderate to severe Y N

abdominal pain, facial swelling, airway swelling) in the absence of hives or a medication known to cause angioedema?

Note: Medical records must be provided.

[If no, then no further questions.]

11. Is the member taking any medications that may exacerbate hereditary angioedema, including angiotensin-converting enzyme (ACE) inhibitors and estrogen-containing medications? Y N

[If yes, then no further questions.]

12. Is the medication requested for the treatment of acute hereditary angioedema attacks? Y N

[If no, skip to question 17.]

13. Is the request for Ruconest? Y N

[If no, skip to question 15.]

14. Will Ruconest be used for laryngeal hereditary angioedema attacks? Y N

[If yes, then no further questions.]

15. Is the request for Berinert, Firazyr, or Kalbitor? Y N

[If no, then no further questions.]

16. Will Berinert, Firazyr, Kalbitor, and/or Ruconest be used together? Y N

[If yes, then no further questions.]

[If no, skip to question 23.]

17. Is the medication requested for prophylaxis against hereditary angioedema? Y N

[If no, then no further questions.]

18. Is the request for Cinryze, Haegarda or Takhzyro? Y N

[If no, then no further questions.]

19. Does the member have signs of current acute angioedema? Y N

[If yes, then no further questions.]

20. Does the member have a history of at least one hereditary angioedema (HAE) attack per month? Y N

[If no, then no further questions.]

21. Does the member meet any of the following: A) treatment with 17 alpha-alkylated androgens (e.g., danazol, stanozolol) for hereditary angioedema prophylaxis was ineffective or not tolerated, B) treatment with anti-fibrinolytic agents (e.g., epsilon aminocaproic acid, tranexamic acid) for hereditary angioedema prophylaxis was ineffective or not tolerated, or C) both classes of medications are contraindicated? Y N

    Note: Medical records must be provided.

    [If no, then no further questions.]

22. Will Cinryze, Takhzyro, and/or Haegarda be used together? Y N

    [If yes, then no further questions.]

23. Is the member's age appropriate for the specific medication requested? Y N

Comments:

I affirm that the information given on this form is true and accurate as of this date.

Prescriber (Or Authorized) Signature **Date**