



State of Oklahoma
SoonerCare

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 Takhzyro®, Cinryze®, Haegarda® and Orladeyo®: _____

(Page 1 of 2)

PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:

University of Oklahoma College of Pharmacy
Pharmacy Management Consultants
Product Based Prior Authorization Unit

Fax: 1-800-224-4014
Phone: 1-800-522-0114 Option 4

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Hereditary Angioedema (HAE) Medications Prior Authorization Form

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

Criteria

For Initial Authorization (continued):

4. For **treatment of acute attacks of HAE** 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: _____

(Page 2 of 2)

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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