Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.
Hereditary Angioedema (HAE) Agents Prior Authorization (PA)
Pharmacy Benefits Prior Authorization Help Desk
Length of Authorizations: Initial- 1 Year; Continuation- 1 Year

Instructions:

This form is used by Kaiser Permanente and/or participating providers for coverage of **Hereditary Angioedema (HAE) Agents.** Please complete all sections, incomplete forms will delay processing. Fax this form back to Kaiser Permanente within 24 hours fax: 1-866-331-2104. If you have any questions or concerns, please call 1-866-331-2103.

KP-MAS Formulary can be found at Pharmacy | Community Provider Portal | Kaiser Permanente

1 – Patient Information

Patient Name: _____ Kaiser Medical ID#: _____ Date of Birth: _____

2 – Prescriber Information

Prescriber Name: _____ Specialty: _____ NPI: _____

Prescriber Address: _____

Prescriber Phone #: _____Prescriber Fax #: _____

3 – Pharmacy Information

Pharmacy Name: _____ Pharmacy NPI: _____

Pharmacy Phone #_____ Pharmacy Fax #: _____

4 – Drug Therapy Requested

Drug Name/Form: _____
Strength:_____
Quantity per Day:_____

Preferred Medications (Quantity Limits)	**Non-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) (see Black Box warning) ☐**icatibant**: 1 dose per attack (plus 1 for emergency) ☐ **Sajazir** ™: 1 dose per attack (plus one for emergency)	☐**Firazyr**®: 1 dose per attack (plus 1 for emergency) ☐**Haegarda**®: 2,000 IU SDV kit (16 kits per 28 days) and 3,000 IU SDV kit (8 kits per 28 days) ☐**Orladeyo**™: 34 capsules per 34 days ☐**Takhzyro**®: 2 vials per 28 days

5– Diagnosis/Clinical Criteria

1. Has the recipient's diagnosis of HAE been confirmed by C1 inhibitor (C1-INh) deficiency or dysfunction (type I or II HAE) as documented by one of the following:
    - C1-INh antigenic level below the lower limit of normal; **OR**
    - C1-INh functional level below the lower limit of normal?

    □ No □ Yes

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

    □ No □ Yes

TREATMENT OF ACUTE HAE ATTACKS: (Berinert® (C1 esterase inhibitor), Firazyr® (icatibant),Kalbitor® (ecallantide), Ruconest® (C1 esterase inhibitor), Sajazir™(icatibant)

1. Will the requested medication be used as monotherapy to treat acute HAE attacks?

    □ No □ Yes

PROPHYLAXIS OF HAE ATTACKS: (Cinryze® (C1 esterase inhibitor), Haegarda® (C1 estarase inhibitor), Orladeyo® (berotralstat), Takhzyro® (ianadelumab-flyo)

1. Will the requested medication be used for prophylaxis of HAE attacks?

    □ No □ Yes

6 – Prescriber Sign-Off

Additional Information –

1. **Please submit chart notes/medical records for the patient that are applicable to this request.**
2. **If the member has not tried the preferred agent(s) please provide a rationale/explanation and any additional supporting information that should be taken into consideration for the requested medication:**

    _____

    _____

I certify that the information provided is accurate. Supporting documentation is available for State audits.

Prescriber Signature:	**Date:**