United Healthcare Community Plan

COMMONWEALTH OF VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

Service Authorization (SA) Form

HEREDITARY ANGIOEDEMA (HAE) MEDICATIONS

If the following information is not complete, correct, or legible, the SA process can be delayed.
Please use one form per member.

MEMBER INFORMATION

Last Name: _____

First Name: _____

Medicaid ID Number: _____

Date of Birth: _____

Weight in Kilograms: _____

PRESCRIBER INFORMATION

Last Name: _____

First Name: _____

NPI Number: _____

Phone Number: _____

Fax Number: _____

DRUG INFORMATION

Because of the risk of anaphylaxis, KALBITOR® should only be administered by a healthcare professional with appropriate medical support to manage anaphylaxis and hereditary angioedema.

Non-Preferred Medications require a trial of two preferred agents

Drug Name/Form: _____

Strength: _____

Dosing Frequency: _____

Length of Therapy: _____

Quantity per Day: _____

(Form continued on next page.)

Member's Last Name: **Member's First Name:**

DIAGNOSIS AND MEDICAL INFORMATION

1. Has the recipient's diagnosis of HAE been confirmed as C1 inhibitor (C1-INh) deficiency/dysfunction (type 1 or 2 HAE) or type 3 HAE (normal C1-INh) 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; **OR**
   - Normal C4 and normal C1-INh level and function with genetic testing demonstrating the presence of a mutation specific for type 3 HAE OR a family history of angioedema together with a demonstrated lack of response to prophylactic therapy for mast cell-mediated angioedema?

   ☐ Yes ☐ No
2. Was the medication prescribed by, or in consultation with, a specialist in allergy, immunology, hematology, pulmonology, or medical genetics?

   ☐ Yes ☐ No
3. For non preferred agents, has the member tried and failed two preferred agents listed on the PDL where applicable for the requested product's intended use? If yes please list the preferred trials.

   ☐ Yes ☐ No

   ☐ Trial one: _____

   ☐ Trial two: _____

TREATMENT OF ACUTE HAE ATTACKS

Such as Berinert® (C1 esterase inhibitor), Firazyr® (icatibant), icatibant, Kalbitor® (ecallantide), Ruconest® (C1 esterase inhibitor), Sajazir™ (icatibant), other FDA indicated medication

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

   ☐ Yes ☐ No

PROPHYLAXIS OF HAE ATTACKS

Such as Cinryze® (C1 esterase inhibitor), Haegarda® (C1 estarase inhibitor), Orladeyo® (berotralstat), Takhzyro® (ianadelumab-flyo), or other FDA indicated medication

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

   ☐ Yes ☐ No

Prescriber Signature (Required) **Date**

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

Submission of documentation does NOT guarantee coverage by the Department of Medical Assistance Services.

Fax this form to 1-866-940-7328

Pharmacy PA Call Center 1-800-310-6826

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