SENTARA COMMUNITY PLAN
(MEDICAID)

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-800-750-9692**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Hereditary Angioedema (HAE)

Drug Requested: (check box below that applies)

PREFERRED Medications (with Quantity Limits)		
❑ **Berinert®** - 4 vials per attack (plus 4 for emergency)	❑ **Cinryze®** - 20 vials per 34 days	❑ **icatibant** - 1 dose per attack (plus 1 for emergency)
❑ **Kalbitor®** - 3 vials per attack (plus 3 for emergency) (see Black Box warning below)	❑ **Sajazir™** - 1 dose per attack (plus 1 for emergency)	

Non-Preferred Medications (with Quantity Limits)	
❑ **Andembry®** - 1.2 ml (1 injection) per 30 days	❑ **Dawnzera™**- 1 vial per 28 days
❑ **Ekterly®**- 1,200mg (four tablets) per attack	❑ **Firazyr®** - 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)	❑ **Orladeyo™** - 1 capsule per day
❑ **Ruconest®** - 2 vials per attack (plus 2 for emergency)	❑ **Takhzyro™** - 2 vials per 28 days

Black Box Warning: 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.

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member Sentara #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

NPI #: _____

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DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Name/Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight (if applicable): _____ **Date weight obtained:** _____

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

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: ❑ Yes ❑ No
   - ❑ 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
2. 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 non-preferred agents, has the member tried and failed two preferred agents listed on the PDL? If yes please list the preferred trials. ❑ Yes ❑ No

     Trial one: _____

     Trial two: _____

TREATMENT OF ACUTE HAE ATTACKS

Berinert® (C1 esterase inhibitor), Ekterly® (sebetralstat) Firazyr® (icatibant), icatibant, Kalbitor® (ecallantide), Ruconest® (C1 esterase inhibitor), Sajazir™(icatibant)

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

   ❑ Yes ❑ No

PROPHYLAXIS OF HAE ATTACKS

Andembry® (garadacimab-gxii), Dawnzera™ (donidalorsen), Cinryze® (C1 esterase inhibitor), Haegarda® (C1 esterase inhibitor), Orladeyo® (berotralstat), Takhzyro® (ianadelumab-flyo)

1. Will the requested medication be used for prophylaxis of HAE attacks? ❑ Yes ❑ No

(Continued on next page)

List pharmaceutical drugs attempted and outcome:

_____

_____

_____

_____

_____

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

_____

_____

_____

_____

_____

Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.

****Previous therapies will be verified through pharmacy paid claims or submitted chart notes.****

REVISED/UPDATED/REFORMATTED: ~~8/1/2017; 4/6/2018; 5/25/2018; 8/17/2018; 10/8/2018; 11/10/2018; 4/3/2019; 5/2/2019; 9/7/2019; 9/15/2025;~~ **10/20/2025**