Health Partners Plans

HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Hereditary Angioedema Agents

Phone: 215-991-4300 Fax back to: 866-240-3712

Health Partners Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL DELAY the review process.

Patient Name:	Prescriber Name:	
HPP Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Patient Primary Phone:	NPI:	*PA PROMISe ID:*
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Line of Business: ☐ Medicaid ☐ CHIP	*Specialty Pharmacy (if applicable):*	
Drug Name:	**Strength:**	
Quantity:	**Refills:**	
Directions:		
Diagnosis Code:	**Diagnosis:**	
HPP's maximum approval time is 12 months but may be less depending on the drug.		

Please attach any pertinent medical history including labs and information for this member that may support approval.

Please answer the following questions and sign.

Q1. Has the patient previously received prior authorization approval for the requested drug?
If Yes, go to 18.

☐ Yes ☐ No

Q2. Is the requested medication being prescribed for an indication that is included in the U.S. Food and Drug Administration (FDA)-approved package labeling OR a medically accepted indication?

☐ Yes ☐ No

Q3. Is the patient age-appropriate according to FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?

☐ Yes ☐ No

Q4. Is the prescribed dose for the requested medication consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?

☐ Yes ☐ No

Q5. Is the requested medication being prescribed by or in consultation with an appropriate specialist, such as an allergist/immunologist, hematologist, or dermatologist?

☐ Yes ☐ No

Q6. Does the patient have a history of contraindication to the prescribed medication?

☐ Yes ☐ No

Q7. With the exception of requests for short term prophylaxis (e.g., surgical or dental procedure), will the requested

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medication be used with another HAE agent for the same indication (i.e., more than one HAE agent for acute treatment or more than one HAE agent for long-term prophylaxis)?

☐ Yes ☐ No

Q8. Does the patient have a diagnosis of HAE Type I or II (with C1 inhibitor deficiency/dysfunction)?

☐ Yes ☐ No

Q9. Has the diagnosis been confirmed by both of the following lab values obtained on two separate instances: A) low C4 complement level (mg/dL), and B) low C1 esterase inhibitor antigenic level (mg/dL) OR low C1 esterase inhibitor functional level [(less than 65%) unless already using an androgen or C1 esterase inhibitor]?

☐ Yes ☐ No

Q10. Does the patient have a diagnosis of HAE Type III (with normal C1 inhibitor)?

☐ Yes ☐ No

Q11. Has the diagnosis been confirmed by all of the following:
A) normal C4 complement level (mg/dL), normal C1 esterase inhibitor antigenic level (mg/dL), and normal C1 esterase inhibitor function level,
B) has a history of recurrent angioedema without urticaria,
C) documentation of a family history of hereditary angioedema OR a hereditary angioedema-causing generic mutation, AND D) history of failure to respond to maximum recommended doses of antihistamines (e.g., cetirizine 20 mg twice daily)?

☐ Yes ☐ No

Q12. Is the patient taking estrogen or an angiotensin-converting enzyme (ACE) inhibitor?

☐ Yes ☐ No

Q13. Is the requested HAE agent being used for long-term prophylaxis?

☐ Yes ☐ No

Q14. Does the patient have poorly controlled HAE based on the prescriber's assessment despite use of an HAE agent for on demand/acute treatment?

☐ Yes ☐ No

Q15. Is the request for a non-preferred HAE agent?

☐ Yes ☐ No

Q16. Does the patient have a documented history of therapeutic failure, contraindication to, or intolerance of the preferred HAE agents approved or medically accepted for the patient's indication?

☐ Yes ☐ No

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Q17. Does the patient have a current history (within the past 90 days) of being prescribed the same requested non-preferred HAE agent?

☐ Yes ☐ No

Q18. Is the prescribed dose for the requested medication consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?

☐ Yes ☐ No

Q19. Is the requested medication being prescribed by or in consultation with an appropriate specialist, such as an allergist/immunologist, hematologist, or dermatologist?

☐ Yes ☐ No

Q20. With the exception of requests for short term prophylaxis (e.g., surgical or dental procedure), will the requested medication be used with another HAE agent for the same indication (i.e., more than one HAE agent for acute treatment or more than one HAE agent for long-term prophylaxis)?

☐ Yes ☐ No

Q21. Is the HAE agent being used for acute treatment?

☐ Yes ☐ No

Q22. Is there documentation of a positive clinical response?

☐ Yes ☐ No

Q23. For long-term prophylaxis, is there a documented reduction in the number of HAE attacks?

☐ Yes ☐ No

Q24. Additional Information:

Prescriber Signature

Date

Updated for 2021