Pharmacy Prior Authorization Form

Fax completed form to: 877.974.4411 toll free, or 616.942.8206

This form applies to: ☒ **Commercial (Traditional)** ☒ **Commercial (Individual/Optimized)** ☐ **Medicaid**

This request is: ☐ **Urgent** (life threatening) ☐ **Non-Urgent** (standard review)

Urgent means the standard review time may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.

Haegarda® (C1 esterase inhibitor [human])

Member

Last Name: _____ First Name: _____

ID #: _____ DOB: _____ Gender: _____

Primary Care Physician: _____

Requesting Provider: _____ Prov. Phone: _____ Prov. Fax: _____

Provider Address: _____

Provider NPI: _____ Contact Name: _____

Date: _____

Product Information

☐ New request ☐ Continuation request

Drug product: ☐ Haegarda 2,000 unit kit ☐ Haegarda 3,000 unit kit

Start date (or date of next dose): _____

Date of last dose (if applicable): _____

Dosing frequency: _____

Drug cost information

The wholesale acquisition cost for one vial is $1,880 - $2,820. The annual cost of treatment will vary depending on the patient's circumstances.

Precertification Requirements

Before this drug is covered, the patient must meet all of the following requirements:

1. Diagnosis of hereditary angioedema type I or type II
    a. Requires submission of two sets of C4, C1-INH protein, and C1-INH function lab results confirming diagnosis
2. Patient has received training for self-administration
3. Haegarda is being used only for prophylaxis of acute attacks
    a. Documentation that patient has acute attacks at least twice per month must be submitted to Priority Health
4. Patient has failed one previous optimized prophylactic treatment (e.g. danazol 600 mg total daily dose)

For continuation, patient must have met the following requirements:

1. Must be compliant on therapy
2. Must have documentation showing a decrease in the frequency of acute attacks from baseline (prior to treatment)

NOTE: Priority Health may require you get a second opinion confirming your diagnosis prior to covering this medication.

All fields must be complete and legible for review. Your office will receive a response via fax. No changes made since 09/2018

Last reviewed 09/2018

Note: Authorization for indications, dosing, or a route of administration not approved by the Food and Drug Administration (FDA) or recognized in CMS-accepted compendia (e.g. DrugDex, AHFS, U.S. Pharmacopeia, and also Clinical Pharmacology for oncology indications only) require supporting evidence for coverage. Please provide two published peer-reviewed literature articles supporting the appropriateness of the drug, the dosing of the drug, or the route of administration to be used for the identified indication.

New request
Priority Health Precertification Documentation

A. What condition is this drug being requested for?

- ☐ Hereditary angioedema, type I or II
- ☐ *Other – the patient's condition is:* _____

Rationale for use: _____

B. Have 2 sets of C4, C1-INH protein, and C1-INH function lab results been submitted to Priority Health?

- ☐ Yes
- ☐ No; *Rationale for use:* _____

C. Has the patient received self-administration training?

- ☐ Yes
- ☐ No

D. Will the patient being using Haegarda for acute or prophylactic treatment?

- ☐ Acute
- ☐ Prophylactic (documentation that the patient has acute attacks at least twice per month must be submitted to Priority Health)

E. Has the patient had a trial of at least one other prophylactic treatment?

- ☐ Yes

Drug	Dose	Dates	Outcome

- ☐ No

Rationale for use: _____

Renewal request
Priority Health Precertification Documentation

A. Has the patient been compliant on therapy?

- ☐ Yes
- ☐ No; *Rationale for use:* _____

B. Has there been a decrease in the frequency of acute attacks since starting Haegarda (documentation must be provided)?

- ☐ Yes
- ☐ No; *Rationale for use:* _____

Additional information

Note: When criteria are met, coverage will be approved for 12 months.

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Last reviewed 09/2018