Nebraska Medicaid Program Request for Prior Authorization of Payment
Hereditary Angioedema (HAE)

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

Member Information

LAST NAME: **FIRST NAME:**

MEDICAID NUMBER: **DATE OF BIRTH:** – –

Prescriber Information

LAST NAME: **FIRST NAME:**

NPI NUMBER: **DEA NUMBER:**

PHONE NUMBER: – – **FAX NUMBER:** – –

Participating Pharmacy

NAME: **REQUEST DATE**

PHONE NUMBER: – – **FAX NUMBER:** – –

Please indicate which medication is being requested and complete the information below:

Preferred:
- ☐ Berinert
- ☐ icatibant acetate
- ☐ Haegarda

Non-preferred:
- ☐ Cinryze
- ☐ Firazyr
- ☐ Orladeyo
- ☐ Ruconest
- ☐ Takhzyro
- ☐ Other: _____

Strength: _____ Dosing schedule: _____ Quantity per month: _____

For current PDL status, please visit: https://nebraska.fhsc.com/PDL/PDLlistings.asp

1. Indicate reason for request: ☐ Angioedema prophylaxis treatment ☐ Treatment of acute hereditary angioedema
2. For HAE treatment, indicate HAE type: ☐ Type I ☐ Type II
3. If the patient is being prescribed the requested medication for a different diagnosis than above, document here (include ICD-10 diagnosis code): _____
4. Is the patient currently treated with the requested medication? ☐ Yes ☐ No

   If yes, when was treatment with the requested medication started? _____
5. For initial authorization, provide current labs of one of the following:
   - ☐ C4 level below the lower limit normal defined by lab, or < 14 mg/dL
   - ☐ C1-INH antigenic level below the lower limit of normal defined by lab, or < 19 mg/dL
   - ☐ C1-INH functional level/percentage below the lower limit of normal defined by lab, or < 50%

(*Form continued on next page*)

Fax This Form to: 866-759-4115
or mail to
Prime Therapeutics State Government Solutions LLC MAP Dept.
Attn: GV – 4201
P.O. Box 64811
St. Paul, MN 55164-0811
Tel: 1-800-241-8335

The following questions apply to requests for prophylaxis agents (Haegarda, Orladeyo, Takhzyro, and Cinryze):

6. Does the patient have a history of two or more attacks monthly? ☐ Yes ☐ No

7. Will the requested medication be used for short term prophylaxis treatment (i.e., surgery, dental, or other medical procedures, etc.)? If so, provide details and date of event.

8. Continuation or renewal of prophylactic therapy requires documentation of any or all of the following:
   - ☐ Achieve and maintain at least a 50% reduction in number of HAE attacks
   - ☐ Achieve and maintain at least a 30% reduction in duration of HAE attacks
   - ☐ Achieve and maintain at least a 60% reduction in days of swelling

9. Does the prescriber verify that the patient is NOT concurrently taking ACE inhibitors, NSAIDs, and estrogen-containing products? ☐ Yes ☐ No
   If not, please explain:

Prescriber Signature (Required) ***Date***

(By signing, the prescriber confirms that the above information is accurate and verifiable by patient records.)

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