Print Reset

CardinalCare
Virginia's Medicaid Program

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: _____

Gender: ☐ **Male** ☐ **Female**

Weight in Kilograms: _____

PRESCRIBER INFORMATION

Last Name: _____

First Name: _____

NPI Number: _____

Phone Number: _____

Fax Number: _____

DRUG INFORMATION

Preferred Medications (Quantity Limits):

☐ **Cinryze®**: 20 vials per 34 days

☐ **Berinert®**: 4 vials per attack (plus 4 for emergency)

☐ **icatibant**: 1 dose per attack (plus 1 for emergency)

☐ **Sajazir™**: 1 dose per attack (plus 1 for emergency)

☐ **Kalbitor®**: 3 vials per attack (plus 3 for emergency) (see Black Box warning below)

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 (Quantity Limits):

☐ **Firazyr®**: 1 dose per attack (plus 1 for emergency)

☐ **Orladeyo®**: 34 capsules per 34 days

☐ **Ruconest®**: 2 vials per attack (plus 2 for emergency)

☐ **Takhzyro®**: 2 vials per 28 days

☐ **Haegarda®**: 2,000 IU SDV kit (16 kits per 28 days) and 3,000 IU SDV kit (8 kits per 28 days)

Drug Name/Form: _____

Strength: _____

Dosing Frequency: _____

Length of Therapy: _____

Quantity per Day: _____

(Form continued on next page.)

Virginia Medicaid Pharmacy Services Portal: http://www.virginiamedicaidpharmacyservices.com

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

DIAGNOSIS AND MEDICAL INFORMATION

1. Has the recipient's diagnosis of HAE been confirmed by C1 inhibitor (C1-INh) deficiency or dysfunction (type 1 or 2 HAE) 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?

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

   ☐ Yes ☐ No

TREATMENT OF ACUTE HAE ATTACKS

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

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

   ☐ Yes ☐ No

PROPHYLAXIS OF HAE ATTACKS

Cinryze® (C1 esterase inhibitor), Haegarda® (C1 estarase inhibitor), Orladeyo® (berotralstat), Takhzyro® (ianadelumab-flyo)

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.

Please include ALL requested information; incomplete forms will delay the SA process.
Submission of documentation does NOT guarantee coverage by the Department of Medical Assistance Services.

The completed form may be: **FAXED TO 800-932-6651**, phoned to 800-932-6648, or mailed to:
Prime Therapeutics Management LLC
Attn: GV – 4201
P.O. Box 64811
St. Paul, MN 55164-0811