GHP Family Pharmacy Customer Service
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Geisinger

HEREDITARY ANGIOEDEMA AGENTS PRIOR AUTHORIZATION FORM *(form effective 01/05/2021)*

Prior authorization guidelines for Hereditary Angioedema (HAE) Agents and Quantity Limits/Daily Dose Limits are available on Geisinger Health Plan's website at https://healthplan.geisinger.org/pharmacy/pharmacy.aspx?strip=true&style=OneGeisinger

☐ New request ☐ Renewal request	Total # pages: _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		DATA 2000 waiver DEA number:	
Name of facility contact:		NPI:	State license #:
Facility contact/phone:		Street address:	
Beneficiary name:		Suite #:	City/state/zip:
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Drug requested:		Strength:
Directions:	Quantity:	Refills:
Diagnosis (*submit documentation*):		Dx code (*required*):

Has the beneficiary been taking the requested medication within the past 90 days?	☐ Yes ☐ No	*Submit documentation of drug regimen and clinical response*
Is the requested agent prescribed by or in consultation with an allergist/immunologist, dermatologist, or hematologist?	☐ Yes ☐ No	*Submit documentation of consultation, if applicable.*
Will the beneficiary be using the requested medication with any other HAE Agents?.	☐ Yes – please list: _____ ☐ No	

Complete the sections below that are applicable to the beneficiary and this request and SUBMIT DOCUMENTATION for each item.

INITIAL requests

- ☐ Does not have a history of a contraindication to the prescribed medication
- ☐ Requested medication is being used for short-term prophylaxis (e.g., surgical or dental procedure)
- ☐ Has a diagnosis of HAE Type I or Type II (with C1 inhibitor deficiency/dysfunction)
  - ☐ Has a low C4 complement level obtained on 2 separate occasions
  - ☐ Has a low C1 esterase inhibitor antigenic level OR functional level (<65% [unless already using an androgen or C1 esterase inhibitor])
- ☐ Has a diagnosis of HAE Type III (with normal C1 inhibitor)
  - ☐ Has a normal C4 complement level (mg/dL)
  - ☐ Has a normal C1 esterase inhibitor antigenic level (mg/dL)
  - ☐ Has a normal C1 esterase inhibitor functional level
  - ☐ Has a history of recurrent angioedema without urticaria
  - ☐ Has a family history of HAE --OR-- ☐ Has an HAE-causing genetic mutation
  - ☐ Failed to respond to maximum recommended doses of antihistamines (e.g., cetirizine 20 mg twice daily)
- ☐ Is taking an estrogen-containing agent (hormone replacement, contraceptives, etc.) – specify indication: _____
- ☐ Is taking an ACE inhibitor (lisinopril, enalapril, ramipril, etc.)
- ☐ Is using the requested medication for long-term prophylaxis
  - ☐ Has poorly controlled HAE despite use of an HAE Agent for on demand/acute treatment
- ☐ For a non-preferred HAE Agent:
  - ☐ Please list the preferred HAE Agents that the beneficiary has had a therapeutic failure, contraindication, or intolerance to

_____

RENEWAL requests

- ☐ Is using the requested medication for long-term prophylaxis and experienced fewer HAE attacks since starting the requested medication
- ☐ Is using the requested medication for acute treatment and experienced a positive clinical response to the requested medication

Please submit to PromptPA https://ghp.promptpa.com OR fax to Geisinger Health Plan at 570-271-5610 the completed form with required clinical documentation.

Prescriber Signature:	Date: