Nevada Medicaid

Submit fax request to: 855-455-3303

Please note: All information below is required to process this request.

Hereditary Angioedema (HAE) Agents
Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED.

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)		
Medication Name:	Strength:	Dosage Form:
	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select all that apply:

Prophylaxis of HAE attacks:

- ❑ The recipient has a diagnosis of hereditary angioedema (HAE) confirmed by C1 inhibitor (S1-INh) deficiency or dysfunctional (Type I or II HAE) as documented by one of the following:
  - C1-INH antigenic level below the lower limit of normal
  - C1-INH functional level below the lower limit of normal
- ❑ The requested medication is for prophylaxis against HAE attacks.
- ❑ The medication is prescribed by or in consultation with an Immunologist or Allergist.

Treatment of acute HAE attacks:

- ❑ The recipient has a diagnosis of HAE confirmed by C1 inhibitor (S1-INh) deficiency or dysfunctional (Type I or II HAE) as documented by one of the following:
  - C1-INH antigenic level below the lower limit of normal
  - C1-INH functional level below the lower limit of normal
- ❑ The requested medication is for the treatment of acute HAE attacks.
- ❑ Only one approved treatment for acute HAE attacks is being used.
- ❑ The medication is prescribed by or in consultation with an Immunologist or Allergist.
- ❑ If the request is for Kalbitor®, recipient is 12 years of age or older.
- ❑ If the request is for Berinert®, one of the following:
  - The recipient had an inadequate response or a contraindication to Ruconest®
  - Recipient is 12 years of age or younger or documentation that the recipient has a history of laryngeal attacks

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.