Fax completed form to Navitus at: 855-668-8553
For questions, please call: 877-908-6023

TEXAS MEDICAID

Drug Prior Authorization
Hereditary Angioedema (HAE) Agents

Request Information (required)
This request is: ☐ **Expedited* (Urgent)** ☐ **Standard (Non-Urgent)** *Expedited means the standard review time may seriously harm the member's life, health, or ability to regain maximum function.

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

Please fill out the following information:

1. Medication Requested (Name):
(Go to #2)

2. Quantity Requested:
(Go to #3)

3. Dose Requested (Strength):
(Go to #4)

4. Dosing Instructions:
(Go to #5)

Required Criteria

5. Provide primary diagnosis including ICD-10 code(s):
(Go to #6)

6. Please indicate the requested drug's formulary status: *(Formulary available at www.txvendordrug.com)

- ◯ Non-Preferred Drug (NPD or NAP)
  (Go to #7)
- ◯ Preferred Drug (PDL)
  (Go to #11)
- ◯ No Status, Drug is not in a Market Basket
  (Go to #11)
- ◯ N/A as this request is for a CHIP/PERINATE member
  (Go to #11)

Preferred Drug List (PDL) Criteria (required for non-preferred products)

7. Has the member been stable on one (1) non-preferred agent for 30-days in the last 180 days?

- ◯ Yes
  (Go to #11)
- ◯ No
  (Go to #8)

8. Has the member failed a 30-day treatment trial with at least one (1) preferred agent in the last 180 days?

- ◯ Yes
  (Go to #11)
- ◯ No
  (Go to #9)

9. Is there a documented allergy or contraindication to preferred agents in this class?

- ◯ Yes
  (Go to #11)
- ◯ No
  (Go to #10)

10. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?

- ◯ Yes
  (Go to #11)
- ◯ No (Deny)
  (Go to #11)

Clinical Criteria (required)

11. Is the member greater than or equal to (≥) two (2) years of age?

- ◯ Yes - And the request is for TAKHZYRO
  (Go to #18)
- ◯ Yes - And the request is for another agent
  (Go to #12)
- ◯ No (Deny)
  (Go to #12)

12. Is the member greater than or equal to (≥) five (5) years of age?

- ◯ Yes - And the request is for BERINERT
  (Go to #18)
- ◯ Yes - And the request is for another agent
  (Go to #13)
- ◯ No (Deny)
  (Go to #13)

13. Is the member greater than or equal to (≥) six (6) years of age?

- ◯ Yes - And the request is for CINRYZE or HAEGARDA
  (Go to #18)
- ◯ Yes - And the request is for another agent
  (Go to #14)
- ◯ No (Deny)
  (Go to #14)

14. Is the member greater than or equal to (≥) 12 years of age?

- ◯ Yes - And the request is for KALBITOR
  (Go to #18)
- ◯ Yes - And the request is for ORLADEYO
  (Go to #17)
- ◯ Yes - And the request is for another agent
  (Go to #15)
- ◯ No (Deny)
  (Go to #15)

15. Is the member greater than or equal to (≥) 13 years of age?

- ◯ Yes - And the request is for RUCONEST
  (Go to #17)
- ◯ Yes - And the request is for another agent
  (Go to #16)
- ◯ No (Deny)
  (Go to #16)

16. Is the member greater than or equal to (≥) 18 years of age?

- ◯ Yes - And the request is for icatibant (FIRAZYR)
  (Go to #18)
- ◯ No (Deny)
  (Go to #17)

17. Does the member have a claim for a P-glycoprotein (P-gp) inducer in the last 60 days?

Examples of P-gp inducers include: carbamazepine (CARBATROL, EPITOL, EQUETRO, TEGRETOL), phenobarbital, phenytoin (DILANTIN, PHENYTEK), RIFAMATE, rifampin (RIFADIN), and RIFATER.

- ◯ Yes (Deny)
  (Go to #18)
- ◯ No
  (Go to #18)

18. Does the member have two (2) claims for the requested agent in the last 180 days?

- ◯ Yes
  (Go to #20)
- ◯ No
  (Go to #19)

19. Does the member have a diagnosis of hereditary angioedema (HAE) in the last 730 days?

- ◯ Yes
  (Go to #20)
- ◯ No (Deny)
  (Go to #20)

20. Does the member have 30 days therapy with an agent that may exacerbate HAE in the last 60 days?

Examples of agents that may exacerbate HAE include:

- Angiotensin-converting enzyme (ACE) inhibitors such as: benazepril, captopril, enalapril (EPANED, VASOTEC), fosinopril, lisinopril (PRINIVIL, QBRELIS), moexipril, quinapril (ACCUPRIL), ramipril (ALTACE), trandolapril.

- Oral contraceptive products such as: APRI, AVIANE, BLISOVI, DAYSEE, ESTARYLLA, JINTELI, JUNEL, LARIN, LO LOESTRIN, LOSEASONIQUE, LOTREL, MICROGESTIN, NECON, NORTREL, OCELLA, PORTIA, SEASONIQUE, SLYND, TAYTULLA, TRI-SPRINTEC, YASMIN, YAZ.

- Other estrogen-containing products such as: CLIMARA, COMBIPATCH, DIVIGEL, DOTTI, ESTRACE, estradiol, EVAMIST, MENOSTAR, ORIAHNN, PREMARIN, PREMPRO, VIVELLE-DOT.

- ◯ Yes (Deny)
  (Go to #21)
- ◯ No
  (Go to #21)

21. Will the member have concurrent therapy with another HAE prophylatic agent?

Examples of HAE prophylactic agents include: BERINERT, CINRYZE, HAEGARDA, KALBITOR, ORLADEYO, TAKHZYRO.

◯ Yes (Deny)
(Go to #22)

◯ No (Approve - 365 days)
(Go to #22)

Additional Information

22. Please provide any additional information we should consider (or attach any supporting documents):
(END)

Submission Information (required)

Prescriber Signature: _____ **Date:** _____

**** PLEASE FAX COMPLETED FORM TO: 855-668-8553 ****

If criteria not met, submit chart documentation with form citing complex medical circumstances.
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