TEXAS MEDICAID
Clinical Edit Prior Authorization
Hereditary Angioedema (HAE) Agents

STEP 1: CLEARLY PRINT AND COMPLETE TO EXPEDITE PROCESSING	
Date:	Prescriber First & Last Name:
Patient First & Last Name:	Prescriber NPI:
Patient Address:	Prescriber Address:
Patient ID:	Prescriber Phone:
Patient Date of Birth:	Prescriber Fax:

STEP 2: MEDICATION INFORMATION	
Medication Requested (Name):	Quantity Requested:
Dose Requested:	Dosing Instructions:

Patient's Primary Diagnosis: _____ ICD 10 Code: _____

Indicate the drug's formulary status: *(Formulary available at www.txvendordrug.com)

☐ Non-Preferred Drug **(NPD or NAP Status, Go to Step 3 - PDL PA Criteria Applies)**

OR ☐ Preferred Drug **(Go to Step 4)**

OR ☐ N/A as this request is for a CHIP / PERINATE client **(Go to Step 4)**

STEP 3: PDL PRIOR AUTHORIZATION CRITERIA FOR NON-PREFERRED PRODUCT

1. Has the client been stable on 1 non-preferred agent for 30-days in the last 180 days?

   ☐ Yes (Go to Step 4 Question 1) ☐ No (Go to #2)

2. Has the client failed a 30-day treatment trial with at least 1 preferred agent in the last 180 days?

   ☐ Yes (Go to Step 4 Question 1) ☐ No (Go to #3)

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

   ☐ Yes (Go to Step 4 Question 1) ☐ No (Go to #4)

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

☐ Yes (Go to Step 4 Question 1) ☐ No (Deny)

STEP 4: CLINICAL PRIOR AUTHORIZATION CRITERIA

1. Is the client greater than or equal to (≥) 5 years of age?

☐ Yes, and request is for BERINERT (Go to #7)

☐ Yes, and request is for another agent (Go to #2)

☐ No (Deny)

2. Is the client greater than or equal to (≥) 6 years of age?

☐ Yes, and request is for CINRYZE or HAEGARDA (Go to #7)

☐ Yes, and request is for another agent (Go to #3)

☐ No (Deny)

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

☐ Yes, and request is for KALBITOR, or TAKHZYRO (Go to #7)

☐ Yes, and request is for ORLADEYO (Go to #6)

☐ Yes, and request is for another agent (Go to #4)

☐ No (Deny)

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

☐ Yes, and request is for RUCONEST (Go to #6)

☐ Yes, and request is for another agent (Go to #5)

☐ No (Deny)

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

☐ Yes, and request is for FIRAZYR (Go to #7)

☐ No (Deny)

6. Does the client have a claim for a P-Glycoprotein (P-gp) inducer in the last 60 days?

Examples of P-gp inducers include carbamazepine (EQUETRO, EPITOL, TEGRETOL, TEGRETOL XR), carbamazepine extended-release (CARBATROL ER), phenytoin (DILANTIN, PHENYTEK), extended phenytoin sodium, phenobarbital, rifampin (RIFADIN, RIFATER), and RIFAMATE CAPSULE

☐ Yes (Deny) ☐ No (Go to #7)

7. Does the client have two (2) claims for the requested agent in the last 180 days? ☐ Yes (Go to #9) ☐ No (Go to #8)
8. Does the client have a diagnosis of hereditary angioedema (HAE) in the last 730 days? ☐ Yes (Go to #9) ☐ No (Deny)
9. Does the client have 30 days therapy with an agent that may exacerbate HAE in the last 60 days? ☐ Yes (Deny) ☐ No (Go to #10)
10. Will client have concurrent therapy with another HAE prophylactic agent? ☐ Yes (Deny) ☐ No (Approve – 365 days)
STEP 5: SIGN AND FAX TO: NAVITUS PRIOR AUTHORIZATION AT: **855-668-8553**
Prescriber Signature: _____ **Date:** _____

If criteria not met, submit chart documentation with form citing complex medical circumstances.
For questions, please call Navitus Customer Care at 1-877-908-6023.