

**OPTIMA HEALTH COMMUNITY CARE
AND
OPTIMA FAMILY CARE
(MEDICAID)**

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request. All other information may be filled in by office staff; **fax to 1-844-348-3720.** No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **Incomplete form will delay authorization process.**

Drug Requested: **Beriner[®]** (C1 Esterase Inhibitor Human) (**J0597**) (**Medical**)

DRUG INFORMATION: Complete information below or authorization process will be delayed.

Drug Form/Strength/Quantity: _____

Dosing Schedule: _____ **Length of Therapy:** _____

Diagnosis: _____ **ICD Code:** _____

Dosing Limit: (see below)

A. Quantity Limit (max daily dose): **Pharmacy Benefit:** None

B. Max Units (per dose and over time): **Medical Benefit:**

20 IU/kg = 80kg = 1600units

Beriner (80kg) 1600 IU vial: *160 billable units per 28 days*

10 units = 1billable

- J0597- 500IU vial: 10 unit = 1billable **AND** NDC 63833-0825-xx 500mg
- Coverage is provided for **12 months** and will be eligible for renewal

CLINICAL CRITERIA: **All** boxes that apply **must** be checked. Incomplete information will delay the authorization process.

Initial Approval Criteria:

I. Treatment of acute attacks of Hereditary Angioedema (HAE):

- Patient must be at least 18 years of age; **AND**
- Patient has a history of moderate to severe cutaneous or abdominal attacks OR mild to severe airway swelling attacks of HAE (i.e. debilitating cutaneous/gastrointestinal symptoms OR laryngeal/pharyngeal/tongue swelling); **AND**
- Confirmation the patient is avoiding the following possible triggers for HAE attacks:
 - Helicobacter pylori infections (confirmed by lab test)
 - Estrogen-containing oral contraceptive agents OR hormone replacement therapy
 - Antihypertensive agents containing ACE inhibitors

II.A. Patient has the following clinical presentation consistent with HAE I:

- Low C1 inhibitor (C1-INH) antigenic level (C1-INH antigenic level below the lower limit of normal as defined by the laboratory performing the test); **AND**
- Low C4 level (C4 below the lower limit of normal as defined by the laboratory performing the test); **AND**

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- Low C1-INH functional level (C1-INH functional level below the lower limit of normal as defined by the laboratory performing the test); **AND**
- Patient has a family history of HAE; **OR**
- Normal C1q level; **OR**

II.B. Patient has the following clinical presentation consistent with HAE II:

- Normal to elevated C1-INH antigenic level; **AND**
- Low C4 level (C4 below the lower limit of normal as defined by the laboratory performing the test); **AND**
- Low C1-INH functional level (C1-INH functional level below the lower limit of normal as defined by the laboratory performing the test); **OR**

II.C. Patient has the following clinical presentation consistent with HAE III:

- Normal C1-INH antigenic level); **AND**
- Normal C4 level; **AND**
- Normal C1-INH functional level; **AND**
- Patient has a known HAE causing C1-INH mutation (i.e., mutation of coagulation factor XII gene); **OR**
- Patient has a family history of HAE; **AND**

Renewal Criteria

- Patient must continue to meet the criteria in section I & II(A-C); **AND**
- Significant improvement in severity and duration of attacks have been achieved and sustained; **AND**
- Absence of unacceptable toxicity from the drug. Examples of unacceptable toxicity include hypersensitivity reactions.

Medication being provided by (check applicable box below):

- Location/site of drug administration:** _____
NPI or DEA # of administering location: _____
- OR**
- Specialty Pharmacy - PropriumRx**

****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.****

Previous therapies will be verified through pharmacy paid claims or submitted chart notes.

Patient Name: _____

Member Optima #: _____ Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

DEA OR NPI #: _____