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 1-800-750-9692**. 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.**

Hereditary Angioedema (HAE)

Drug Requested **(select applicable drug below):**

PREFERRED Medications (with Quantity Limits)		
❑ **Cinryze®** (C1 Esterase Inhibitor Human) – **20 vials per 34 days**	❑ **Berinert®** (C1 Esterase Inhibitor Human) – **4 vials per attack (plus 4 for emergency)**	❑ **Kalbitor®** (C1 Esterase Inhibitor Human) – **3 vials per attack (plus 3 for emergency)**

Non-Preferred Medications (with Quantity Limits)	
❑ **Firazyr®** (icatibant) – **1 dose per attack (plus 1 for emergency)**	❑ **Ruconest®** (C1 Inhibitor Recombinant) – **2 vials per attack (plus 2 for emergency)**

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

Drug Name: ____

Drug Form/Strength/Quantity: ______________________________________

Dosing Schedule: ______________________________ **Length of Therapy:** ____________

Diagnosis: ______________________________________ **ICD Code**: ________________

CLINICAL CRITERIA: Check boxes below to qualify. If **not** checked, authorization process will be delayed.

Hereditary Angioedema (HAE) Medications – to receive an approval for these drugs, complete the following questions.

1. Is the prescribing physician a board certified allergist, immunologist, or hematologist? ❑ Yes ❑ No

   If **Yes**, document the physician's specialty: ______________________________________

For prophylaxis use, do any of the following criteria apply to the patient? Please check all that apply.

2. HAE attacks occur at least once monthly? ❑ Yes ❑ No
3. Disabled at least 5 days per month? ❑ Yes ❑ No

(continued on next page)

4. History of attacks with airway compromise/hospitalization? ❑ Yes ❑ No
5. History of prior prophylaxis with Danazol (i.e., contraindicated, developed toxicity, diminished efficacy)? ❑ Yes ❑ No

   If **Yes**, document details: ____

   ____

List pharmaceutical agents attempted and outcome:

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Medical Necessity: Provide clinical evidence that the preferred agent(s) will **not** provide adequate benefit and/or provide clinical rationale for quantity exception requests:

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****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 #: ____

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