OPTIMA HEALTH COMMUNITY CARE

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 forms will delay the process.***

Drug Requested: Haegarda® (C1 esterase inhibitor subcutaneous, human) ***(MEDICAID ONLY)***

DRUG INFORMATION: Check applicable box and complete the information below. If incomplete, authorization process will be delayed.

Drug Form/Strength: _____

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

Diagnosis: _____ **ICD Code**: _____

Quantity Limit: 2,000 units SDV kit: 16 kits per 28 days; 3,000 units SDV kit: 8 kits per 28 days

DIAGNOSIS AND MEDICAL INFORMATION: ALL appropriate boxes below MUST be checked to qualify. If not checked, authorization process will be delayed. Length of Approved Authorization: One (1) year

- Is the prescribing physician a board-certified: ❑ **allergist** ❑ **immunologist** ❑ **hematologist?**
  ❑ Yes ❑ No
- Is member at least 12 years of age or older**?** ❑ Yes ❑ No
- **For prophylaxis use, do any of the following criteria apply to the patient? Please check *all* that apply.**
  - ❑ HAE attacks occur at least once monthly? ❑ Yes ❑ No
  - ❑ Disabled at least 5 days per month? ❑ Yes ❑ No
  - ❑ History of attacks with airway compromise/hospitalization? ❑ Yes ❑ No
  - ❑ History of prior prophylaxis with danazol? ❑ Yes ❑ No
    - Danazol contraindicated (pediatric, hepatic, or renal impairment, pregnancy, breast-feeding, , abnormal genital bleeding)?
      ❑ Yes ❑ No
    - Developed Danazol toxicity?
    - Diminished Danazol efficacy?

MEDICAL NECESSITY: Provide clinical evidence that the Preferred Drug(s) will not provide adequate benefit and/or provide clinical rationale for quantity exception requests.

_____

_____

Medication being provided by (check applicable box below):

❑ **Physician's office** **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 #: _____ Member Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

DEA OR NPI #: _____

***REVISED/UPDATED: 12/26/2017**