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: Hereditary Angioedema (HAE Medications) ***MEDICAID ONLY***

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

Preferred Medications (Quantity Limits)	Non-preferred Medications (Quantity Limits)
❑ **Berinert®** – 4 vials per attack (plus 4 for emergency)	❑ Firazyr® – 1 dose per attack (plus 1 for emergency)
❑ **Cinryze™** – 20 vials per 34 days	❑ Ruconest® – 2 vials per attack (plus 2 for emergency)
❑ **Kalbitor®** – 3 vials per attack (plus 3 for emergency)	

Drug Name/Form: _____ **Strength:** _____

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

Diagnosis: _____ **ICD Code**: _____

DIAGNOSIS AND MEDICAL INFORMATION: Check ALL appropriate boxes below. If not checked, authorization process will be delayed.

Is the prescribing physician a board-certified: ❑ **allergist** ❑ **immunologist** ❑ **hematologist?** ❑ 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 (i.e., contraindicated, developed toxicity, diminished efficacy)? ❑ Yes ❑ No

Document details: _____

- **List pharmaceutical agents attempted and outcome:**

1. _____
2. _____

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:** ~~6/29/2017;~~ **8/31/2017**