

# OPTIMA HEALTH PLAN

## 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 1-844-723-2094. 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:** Berinert® (C1 Esterase Inhibitor Human) (J0597)

**DRUG INFORMATION:** Complete information below. If incomplete, 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

Berinert (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**
- 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**

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**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):**

**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 #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Prescriber Name: \_\_\_\_\_

Prescriber Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Office Contact Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

**DEA OR NPI #:** \_\_\_\_\_

\*Approved by Pharmacy and Therapeutics Committee: 12/12/2016  
REVISED/UPDATED: 3/28/2017, 7/24/2017;