COMMONWEALTH OF VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

Service Authorization (SA) Form

HEREDITARY ANGIOEDEMA (HAE) MEDICATIONS

If the following information is not complete, correct, or legible, the SA process can be delayed.
Please use one form per member.

MEMBER INFORMATION

Last Name: | | | | | | | | | | | | |

First Name: | | | | | | | | | | | | |

Medicaid ID Number: | | | | | | | | | | | | |

Date of Birth: | | | – | | | – | | | | |

Gender: ☐ **Male** ☐ **Female**

Weight in Kilograms: ______________________________

PRESCRIBER INFORMATION

Last Name: | | | | | | | | | | | | |

First Name: | | | | | | | | | | | | |

NPI Number: | | | | | | | | | | |

Phone Number: | | | | – | | | | – | | | | |

Fax Number: | | | | – | | | | – | | | | |

DRUG INFORMATION

Preferred Medications (Quantity Limits):

☐ **Cinryze®** – 20 vials per 34 days

☐ **Berinert®** – 4 vials per attack (plus 4 for emergency)

☐ **icatibant**: 1 dose per attack (plus 1 for emergency)

☐ **Sajazir™**: 1 dose per attack (plus 1 for emergency)

☐ **Kalbitor®** – 3 vials per attack (plus 3 for emergency) (see Black Box warning below)

Because of the risk of anaphylaxis, KALBITOR® should only be administered by a healthcare professional with appropriate medical support to manage anaphylaxis and hereditary angioedema.

Non-Preferred Medications (Quantity Limits):

☐ **Firazyr®**: 1 dose per attack (plus 1 for emergency)

☐ **Orladeyo®**: 34 capsules per 34 days

☐ **Ruconest®**: 2 vials per attack (plus 2 for emergency)

☐ **Takhzyro®**: 2 vials per 28 days

☐ **Haegarda®**: 2,000 IU SDV kit (16 kits per 28 days) and 3,000 IU SDV kit (8 kits per 28 days)

Drug Name/Form: ______________________________

Strength: ______________________________

Dosing Frequency: ______________________________

Length of Therapy: ______________________________

Quantity per Day: ______________________________

(Form continued on next page.)

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Member's Last Name: | | | | | | | | | | | | |

Member's First Name: | | | | | | | | | | | | |

DIAGNOSIS AND MEDICAL INFORMATION

1. Has the recipient's diagnosis of HAE been confirmed by C1 inhibitor (C1-INh) deficiency or dysfunction (type 1 or 2 HAE) as documented by one of the following:
   - C1-INh antigenic level below the lower limit of normal; **OR**
   - C1-INh functional level below the lower limit of normal?

   ☐ Yes ☐ No

2. Was the medication prescribed by, or in consultation with, a specialist in allergy, immunology, hematology, pulmonology, or medical genetics?

   ☐ Yes ☐ No

TREATMENT OF ACUTE HAE ATTACKS

Berinert® (C1 esterase inhibitor), Firazyr® (icatibant), icatibant, Kalbitor® (ecallantide), Ruconest® (C1 esterase inhibitor), Sajazir™ (icatibant)

1. Will the requested medication be used as mono therapy to treat acute HAE attacks?

   ☐ Yes ☐ No

PROPHYLAXIS OF HAE ATTACKS

Cinryze® (C1 esterase inhibitor), Haegarda® (C1 estarase inhibitor), Orladeyo® (berotralstat), Takhzyro® (ianadelumab-flyo)

1. Will the requested medication be used for prophylaxis of HAE attacks?

   ☐ Yes ☐ No

____ ____________________

Prescriber Signature (Required) **Date**

By signature, the physician confirms the above information is accurate and verifiable by member records.

Please include ALL requested information; incomplete forms will delay the SA process.
Submission of documentation does NOT guarantee coverage by the Department of Medical Assistance Services.

The completed form may be: **FAXED TO 800-932-6651**, phoned to 800-932-6648, or mailed to:

Magellan Medicaid Administration/ATTN: MAP
11013 W. Broad Street, Glen Allen, VA 23060