Gateway Health
It's Wholecare.

Gateway Health Plan
Pharmacy Division
Phone 800-392-1147 Fax 888-245-2049

I. Requirements for Prior Authorization of Hereditary Angioedema (HAE) Agents

A. Prescriptions That Require Prior Authorization

All prescriptions for Hereditary Angioedema (HAE) Agents must be prior authorized.

B. Review of Documentation for Medical Necessity

In evaluating a request for prior authorization of a prescription for an HAE Agent, the determination of whether the requested prescription is medically necessary will take into account whether the beneficiary:

1. Is prescribed the HAE Agent for an indication that is included in the U.S. Food and Drug Administration (FDA)-approved package labeling OR a medically accepted indication; **AND**

2. Is age-appropriate according to FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature; **AND**

3. Is prescribed a dose that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature; **AND**

4. Is prescribed the HAE Agent by or in consultation with an appropriate specialist (i.e., an allergist/immunologist, hematologist, or dermatologist); **AND**

5. Does not have a history of a contraindication to the prescribed medication; **AND**

6. With the exception of requests for short-term prophylaxis (e.g., surgical or dental procedure), will not be using the requested HAE Agent with another HAE Agent for the same indication (i.e., more than one HAE Agent for acute treatment or more than one HAE Agent for long-term prophylaxis); **AND**

7. For a diagnosis of HAE Type I or II (with C1 inhibitor deficiency/dysfunction), has **both** of the following lab values obtained on two separate instances:

   a. Low C4 complement level (mg/dL)

   b. At least **one** of the following:
      i. Low C1 esterase inhibitor antigenic level (mg/dL)
      ii. Low C1 esterase inhibitor functional level [(<65%) unless already using an androgen or C1 esterase inhibitor];

AND

8. For a diagnosis of HAE Type III (with normal C1 inhibitor), **all** of the following:

   a. Has **all** of the following lab values:
      i. Normal C4 complement level (mg/dL),
      ii. Normal C1 esterase inhibitor antigenic level (mg/dL),
      iii. Normal C1 esterase inhibitor functional level,

Gateway Health Plan
Pharmacy Division
Phone 800-392-1147 Fax 888-245-2049

b. Has a history of recurrent angioedema without urticaria,

c. **One** of the following:
   i. Has documentation of a family history of hereditary angioedema
   ii. Has a hereditary angioedema-causing genetic mutation,

d. Failed to respond to maximum recommended doses of antihistamines (e.g., cetirizine 20 mg twice daily);

AND

9. Is not taking an estrogen-containing medication unless medically necessary or an ACE inhibitor; **AND**

10. If prescribed the HAE Agent for long-term prophylaxis, has poorly controlled HAE based on the prescriber's assessment despite use of an HAE Agent for on demand/acute treatment; **AND**

11. For a non-preferred HAE Agent, **one** of the following:

a. Has a history of therapeutic failure, contraindication, or intolerance to the preferred HAE Agents approved or medically accepted for the beneficiary's indication
b. Has a current history (within the past 90 days) of being prescribed the same non-preferred HAE Agent

See the Preferred Drug List (PDL) for the list of preferred HAE Agents at https://papdl.com/preferred-drug-list;

NOTE: If the beneficiary does not meet the clinical review guidelines listed above but, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the beneficiary, the request for prior authorization will be approved.

FOR RENEWALS OF PRIOR AUTHORIZATION FOR AN HAE AGENT: The determination of medical necessity of a request for renewal of a prior authorization for an HAE agent that was previously approved will take into account whether the beneficiary:

1. Is prescribed a dose that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature; **AND**

2. Is prescribed the HAE Agent by or in consultation with an appropriate specialist (i.e., an allergist/immunologist, hematologist, or dermatologist); **AND**

3. With the exception of requests for short-term prophylaxis, will not be using the requested HAE Agent with another HAE Agent for the same indication (i.e., more than one HAE Agent for acute treatment or more than one HAE Agent for long-term prophylaxis); **AND**

Gateway Health Plan
Pharmacy Division
Phone 800-392-1147 Fax 888-245-2049

4. If prescribed the HAE Agent for acute treatment, has documentation of a positive clinical response to the requested medication; **AND**

5. If prescribed the HAE Agent for long-term prophylaxis, has a documented reduction in the number of HAE attacks

   NOTE: If the beneficiary does not meet the clinical review guidelines listed above but, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the beneficiary, the request for prior authorization will be approved.

C. Clinical Review Process

Prior authorization personnel will review the request for prior authorization and apply the clinical guidelines in Section B. above to assess the medical necessity of a prescription for an HAE Agent. If the guidelines in Section B. are met, the reviewer will prior authorize the prescription. If the guidelines are not met, the prior authorization request will be referred to a physician reviewer for a medical necessity determination. Such a request for prior authorization will be approved when, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the beneficiary.

Gateway Health
It's Wholecare.

Gateway Health Plan
Pharmacy Division
Phone 800-392-1147 Fax 888-245-2049

HEREDITARY ANGIOEDEMA AGENTS PRIOR AUTHORIZATION FORM (*form effective 01/05/2021*)

☐New request ☐Renewal request	# of pages: _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		NPI:	State license #:
LTC facility contact/phone:		Street address:	
Beneficiary name:		Suite #:	City/state/zip:
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Drug requested:	Strength:	
Dose/directions:	Quantity:	Refills:
Diagnoses (*submit documentation*):	Dx codes (*required*):	
Has the beneficiary been taking the requested medication within the past 90 days?	☐Yes ☐No	*Submit documentation of drug regimen and clinical response.*
Is the requested agent prescribed by or in consultation with an allergist/immunologist, dermatologist, or hematologist?	☐Yes ☐No	*Submit documentation of consultation, if applicable.*
Will the beneficiary be using the requested medication with any other HAE Agents?	☐Yes – please list: _____ ☐No	

Complete the sections below that are applicable to the beneficiary and this request and SUBMIT DOCUMENTATION for each item.

INITIAL requests

☐Requested medication is being used for short-term prophylaxis (e.g., surgical or dental procedure)
☐Has a diagnosis of HAE Type I or Type II (with C1 inhibitor deficiency/dysfunction)
- ☐Has a low C4 complement level obtained on 2 separate occasions
- ☐Has a low C1 esterase inhibitor antigenic level OR functional level (<65% [unless already using an androgen or C1 esterase inhibitor])

☐Has a diagnosis of HAE Type III (with normal C1 inhibitor)
- ☐Has a normal C4 complement level (mg/dL)
- ☐Has a normal C1 esterase inhibitor antigenic level (mg/dL)
- ☐Has a normal C1 esterase inhibitor functional level
- ☐Has a history of recurrent angioedema without urticaria
- ☐Has a family history of HAE --OR-- ☐Has an HAE-causing genetic mutation
- ☐Failed to respond to maximum recommended doses of antihistamines (e.g., cetirizine 20 mg twice daily)

☐Is taking an estrogen-containing agent (hormone replacement, contraceptives, etc.) – specify indication: _____
☐Is taking an ACE inhibitor (lisinopril, enalapril, ramipril, etc.)
☐Is using the requested medication for long-term prophylaxis
- ☐Has poorly controlled HAE despite use of an HAE Agent for on demand/acute treatment

☐For a non-preferred HAE Agent:
- ☐Has a history of trial and failure of or contraindication or intolerance to the preferred agents in this class that are approved or medically accepted for treatment of the beneficiary's condition (*Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred agents in this class.)*

RENEWAL requests

☐Is using the requested medication for long-term prophylaxis and experienced fewer HAE attacks since starting the requested medication
☐Is using the requested medication for acute treatment and experienced a positive clinical response to the requested medication

PLEASE FAX COMPLETED FORM TO GATEWAY – PHARMACY DIVISION

Prescriber Signature:	Date: