Commonwealth of Massachusetts
MassHealth Drug Utilization Review Program
P.O. Box 2586, Worcester, MA 01613-2586
Fax: (877) 208-7428 **Phone:** (800) 745-7318

Print Clear

Hereditary Angioedema Agents Prior Authorization Request

MassHealth reviews requests for prior authorization (PA) on the basis of medical necessity only. If MassHealth approves the request, payment is still subject to all general conditions of MassHealth, including current member eligibility, other insurance, and program restrictions. MassHealth will notify the requesting provider and member of its decision. Keep a copy of this form for your records. If faxing this form, please use black ink.

Additional information about these agents, including PA requirements and preferred products, can be found within the MassHealth Drug List at **www.mass.gov/druglist.**

Member information

Last name _____ First name _____ MI _____

MassHealth member ID # _____ Date of birth _____

Gender (Check one.) ☐ F ☐ M Member's place of residence ☐ home ☐ nursing facility

Diagnosis

Is the member diagnosed with hereditary angioedema? ☐ Yes ☐ No

Please provide any lab tests that confirm the diagnosis.

Test _____ Lab value _____ Lab reference range _____ Date obtained _____

Test _____ Lab value _____ Lab reference range _____ Date obtained _____

Test _____ Lab value _____ Lab reference range _____ Date obtained _____

Please document the baseline frequency of hereditary angioedema attacks: _____ attacks/month

Medication information

Medication requested

☐ Berinert (c1 esterase inhibitor, human)
☐ Cinryze (c1 esterase inhibitor, human)
☐ Haegarda (c1 esterase inhibitor, human)
☐ icatibant
☐ Kalbitor (ecallantide)^
☐ Orladeyo (berotralstat)
☐ Ruconest (c1 esterase inhibitor, recombinant)
☐ Takhzyro (lanadelumab-flyo)

Instructions for use _____

^ *This drug is available through the health care professional who administers the drug. MassHealth does not pay for this drug to be dispensed through a retail pharmacy.*

☐ Prophylaxis therapy ☐ Treatment of acute attacks

Place of administration ☐ Clinician's office ☐ Home

Has the member been instructed to self-administer the medication? ☐ Yes ☐ No

Please indicate billing preference. ☐ Pharmacy ☐ Prescriber in-office ☐ Hospital outpatient

For hospital outpatient billing, provide department-specific facility NPI. _____

Drug NDC (if known) or service code _____

Is the member under the care of an allergist or immunologist? ☐ Yes ☐ No

If yes, and the requesting provider is not the allergist or immunologist, please provide consult notes regarding the member's diagnosis.

Section I. For Cinryze, Haegarda, Orladeyo, and Takhzyro requests, please complete the following.

1. Is the member experiencing more than one HAE event per month? ☐ Yes ☐ No
2. Does the member have a history of recurrent laryngeal attacks? ☐ Yes ☐ No

Section II. For recertification requests for Berinert, icatibant, Kalbitor, or Ruconest, please complete the following.

1. Has the member used the previously approved product?
   ☐ Yes. Please indicate the quantity used. _____
   ☐ No
2. Has the previously approved product expired?
   ☐ Yes. Please indicate the quantity expired. _____
   ☐ No
3. Does the member have sufficient medication available to treat one attack? ☐ Yes ☐ No

Section III. Please complete for all requests for non-preferred drug products if one or more preferred drug products have been designated for this class of drugs.

If one or more preferred drug products have been designated for this class of drugs, and if you are requesting PA for a non-preferred drug product, please provide medical necessity for prescribing the non-preferred drug product rather than the preferred drug product.

_____

_____

Prescriber information

Last name* _____ First name* _____ MI _____

NPI* _____ Individual MH Provider ID _____

DEA No. _____ Office Contact Name _____

Address _____ City _____ State _____ Zip _____

E-mail address _____

Telephone No.* _____ Fax No.* _____

**Required*

Prescribing provider's attestation, signature, and date

I certify under the pains and penalties of perjury that I am the prescribing provider identified in the Prescriber information section of this form. Any attached statement on my letterhead has been reviewed and signed by me. I certify that the medical necessity information (per 130 CMR 450.204) on this form is true, accurate, and complete, to the best of my knowledge. I understand that I may be subject to civil penalties or criminal prosecution for any falsification, omission, or concealment of any material fact contained herein.

Prescribing provider's signature (Signature and date stamps, or the signature of anyone other than the provider, are not acceptable.)

Signature required _____

Printed name of prescribing provider _____ Date _____