MOLINA HEALTHCARE

Texas Standard Prior Authorization Form Addendum

Molina Healthcare of Texas

Hereditary Angioedema (HAE) (Medicaid)

This fax machine is located in a secure location as required by HIPAA Regulations. Complete / Review information, sign, and date. Fax signed forms to Molina Pharmacy Prior Authorization Department at **1-888-487-9251**. Please contact Molina Pharmacy Prior Authorization Department at **1-855-322-4080** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of HAE (Medicaid).

Drug Name (select from list of drugs shown / provide drug information)			
BERINERT UNIT KIT	CINRYZE UNIT VIAL	FIRAZYR SYRINGE	HAEGARDA UNIT VIAL
KALBITOR VIAL	ORLADEYO CAPSULE	RUCONEST UNIT VIAL	TAKHZYRO VIAL

Patient Information	
Patient Name:	
Patient ID:	
Patient DOB:	

Prescribing Physician	
Physician Name:	
Physician Phone:	
Physician Fax:	
Physician Address:	
City, State, Zip:	

Diagnosis:	ICD Code:
Directions for administration:	

*****Please include all relevant clinical notes, lab work, medication history and any other applicable documentation.**

Please circle the appropriate answer for each question.

1. Is the requested drug required per court order? (court order required) Y N
   If the answer to this question is yes, approved for 365 days.
   If the answer to this question is no, go to question 2.

2. Is the request for Berinert? Y N
   If the answer to this question is yes, go to question 3.
   If the answer to this question is no, go to question 4.

3. Is the patient greater than or equal to 5 years of age? Y N
   If the answer to this question is yes, go to question 14.
   If the answer to this question is no, denied.

4. Is the request for Cinryze or Haegarda? Y N
   If the answer to this question is yes, go to question 5.
   If the answer to this question is no, go to question 6.

5. Is the patient greater than or equal to 6 years of age? Y N
If the answer to this question is yes, go to question 14.
If the answer to this question is no, denied.

6. Is the patient greater than or equal to 12 years of age? Y N
If the answer to this question is yes, go to question 7.
If the answer to this question is no, denied.

7. Is the request for Kalbitor or Takhzyro? Y N
If the answer to this question is yes, go to question 14.
If the answer to this question is no, go to question 8.

8. Is the request for Orladeyo? Y N
If the answer to this question is yes, go to question 13.
If the answer to this question is no, go to question 9.

9. Is the request for Ruconest? Y N
If the answer to this question is yes, go to question 10.
If the answer to this question is no, go to question 11.

10. Is the patient greater than or equal to 13 years of age? Y N
If the answer to this question is yes, go to question 13.
If the answer to this question is no, denied.

11. Is the request for Firazyr? Y N
If the answer to this question is yes, go to question 12.
If the answer to this question is no, denied.

12. Is the patient greater than or equal to 18 years of age? Y N
If the answer to this question is yes, go to question 14.
If the answer to this question is no, denied.

13. Does the patient have a claim for a P-gp inducer in the last 60 days? Y N
If the answer to this question is yes, denied.
If the answer to this question is no, go to question 14.

14. Does the patient have 2 claims for the requested agent in the last 180 days? Y N
If the answer to this question is yes, go to question 16.
If the answer to this question is no, go to question 15.

15. Does the patient have a diagnosis of hereditary angioedema (HAE) in the last 730 days? Y N
If the answer to this question is yes, go to question 16.
If the answer to this question is no, denied.

16. Does the patient have 30 days therapy with an agent that may exacerbate HAE in the last 60 days? Y N
If the answer to this question is yes, denied.
If the answer to this question is no, go to question 17.

17. Will patient have concurrent therapy with another HAE prophylactic agent? Y N
If the answer to this question is yes, denied.
If the answer to this question is no, go to question 18.

18. Is this request for a non-preferred drug? Y N
If the answer to this question is yes, go to question 19.
If the answer to this question is no, approved for 365 days.

19. Has the patient failed a 30-day treatment trial with at least 1 preferred agent within the last 180 days? Y N
If the answer to this question is yes, approved for 365 days.
If the answer to this question is no, go to question 20.

20. Is there a documented allergy or contraindication to preferred agents in this class? Y N
If the answer to this question is yes, approved 365 days.
If the answer to this question is no, go to question 21.

21. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions? Y N
If the answer to this question is yes, approved 365 days.
If the answer to this question is no, denied.

Comments:

I affirm that the information given on this form is true and accurate as of this date.

_____ _____

Prescriber (or Authorized) Signature Date