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| Criteria 1 | Non-Preferred: Berinert, Cinryze, Icatibant Acetate, Kalbitor |
| Criteria 2 | Preferred: Haegarda (PA), Ruconest (PA), Takhzyro (PA) |

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| **Criteria Title** | Respiratory Agents: Hereditary Angioedema | | |
| **Criteria Subtitle** | Non-Preferred Products | | |
| **Approval Level** | GCNSeqNo | | |
| **Products**   |  |  | | --- | --- | | Preferred |  | | Non-Preferred | X | | Brand |  | | Generic |  | | Other |  | | Drug Name | Corresponding Code(s) | Type of Code (GCNSeqNo, HICL, NDC) |
| BERINERT | 068384 | GCNSeqNo |
| CINRYZE | 040429 | GCNSeqNo |
| ICATIBANT ACETATE | 064564 | GCNSeqNo |
| KALBITOR | 065953 | GCNSeqNo |

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| **Sequence Number** | **Question ID** | **Default Next Question ID** | **Question Type** | **Question Text** | **Choice Text** | **Next Question ID** |
| 1 | 0999 |  | Select | Is the patient new to therapy (initial authorization request) or continuing therapy (re-authorization request)? | New Start (initial authorization request) | 1000 |
| Continuation (re-authorization request) | 2000 |
| 2 | 1000 |  | Select | Is this request being prescribed in accordance with Food and Drug Administration (FDA) approved labeling? | Y | 1001 |
| N | 1235 |
| 3 | 1001 |  | Select and Free Text | Has the provider submitted documentation of the patient’s diagnosis (i.e., C1-INH deficiency or dysfunction (Type I or II HAE))?  If yes, please submit documentation. | Y | 1002 |
| N | 1235 |
| 4 | 1002 |  | Select | What will the requested drug be used for? | Acute Treatment | 1003 |
| Prophylaxis | 1003 |
| Other | 1235 |
| 5 | 1003 |  | Select and Free Text | Has the provider submitted documentation of at-home administration?  If yes, please submit documentation. | Y | 1004 |
| N | 1235 |
| 6 | 1004 |  | Select and Free Text | Has the patient had an inadequate clinical response of at least 60 days with at least one preferred drug?  If yes, please submit the medication trials and dates. | Y | 1006 |
| N | 1005 |
| 7 | 1005 |  | Select and Free Text | Has the provider submitted documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances)?  If yes, please submit the medication name and reason for inability to use. | Y | 1006 |
| N | 1236 |
| 8 | 1006 |  | Select | Is the request for any of the following:  1) a nonsolid oral dosage formulation  2) a non-preferred extended release formulation  3) a non-preferred brand name that has a preferred generic product | Y | 1007 |
| N | END (Pending Manual Review) |
| 9 | 1007 |  | Select and Free Text | Has the provider submitted documentation of medical necessity for the requested product (i.e. medical reasons for why the patient cannot be changed to a solid oral dosage formulation, inadequate clinical response with a product’s immediate release formulation, or inadequate clinical response or allergy of two or more generic labelers)? | Y | END (Pending Manual Review) |
| N | 1235 |
| 10 | 2000 |  | Select and Free Text | Has the provider submitted documentation of the patient’s clinical response to treatment and ongoing safety monitoring?  If yes, please submit documentation. | Y | END (Pending Manual Review) |
| N | 1235 |
| 11 | 1235 |  | Free Text | Please provide the rationale for the medication being requested. | END (Pending Manual Review) | |
| 12 | 1236 |  | Free Text | Please explain the reason(s) why the patient is unable to use medications not requiring prior approval. | END (Pending Manual Review) | |

LENGTH OF AUTHORIZATIONS: Initial: 90 days; Subsequent: 180 Days

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| **Last Approved** | 4/13/2023 |
| **Other** |  |

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| **Criteria Title** | Respiratory Agents: Hereditary Angioedema | | |
| **Criteria Subtitle** | Preferred Products | | |
| **Approval Level** | GCNSeqNo | | |
| **Products**   |  |  | | --- | --- | | Preferred | X | | Non-Preferred |  | | Brand |  | | Generic |  | | Other |  | | Drug Name | Corresponding Code(s) | Type of Code (GCNSeqNo, HICL, NDC) |
| HAEGARDA | 077523 | GCNSeqNo |
| HAEGARDA | 077524 | GCNSeqNo |
| RUCONEST | 067598 | GCNSeqNo |
| TAKHZYRO | 078791 | GCNSeqNo |
| TAKHZYRO | 081825 | GCNSeqNo |

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| **Sequence Number** | **Question ID** | **Default Next Question ID** | **Question Type** | **Question Text** | **Choice Text** | **Next Question ID** |
| 1 | 0999 |  | Select | Is the patient new to therapy (initial authorization request) or continuing therapy (re-authorization request)? | New Start (initial authorization request) | 1000 |
| Continuation (re-authorization request) | 2000 |
| 2 | 1000 |  | Select | Is this request being prescribed in accordance with Food and Drug Administration (FDA) approved labeling? | Y | 1001 |
| N | 1235 |
| 3 | 1001 |  | Select and Free Text | Has the provider submitted documentation of the patient’s diagnosis (i.e., C1-INH deficiency or dysfunction (Type I or II HAE))?  If yes, please submit documentation. | Y | 1002 |
| N | 1235 |
| 4 | 1002 |  | Select | What will the requested drug be used for? | Acute Treatment | 1003 |
| Prophylaxis | 1003 |
| Other | 1235 |
| 5 | 1003 |  | Select and Free Text | Has the provider submitted documentation of at-home administration?  If yes, please submit documentation. | Y | END (Pending Manual Review) |
| N | 1235 |
| 6 | 2000 |  | Select and Free Text | Has the provider submitted documentation of the patient’s clinical response to treatment and ongoing safety monitoring?  If yes, please submit documentation. | Y | END (Pending Manual Review) |
| N | 1235 |
| 7 | 1235 |  | Free Text | Please provide the rationale for the medication being requested. | END (Pending Manual Review) | |

LENGTH OF AUTHORIZATIONS: Initial: 90 days; Subsequent: 180 Days

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| **Last Approved** | 4/13/2023 |
| **Other** |  |