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

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
☐ Ruconest (c1 esterase inhibitor, recombinant)
☐ Takhzyro (lanadelumab-flyo)

Instructions for use ____

☐ Prophylaxis therapy ☐ Treatment of acute attacks

Place of administration ☐ Clinicians office ☐ Home

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

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, 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, 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.

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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 ______________________