

AETNA BETTER HEALTH® OF VIRGINIA REQUEST FORM  
HEREDITARY ANGIOEDEMA (HAE) MEDICATIONS

Fax back to: 1-855-799-2553

If the following information is not complete, correct, or legible, the PA process can be delayed. Please use one form per member.

**MEMBER INFORMATION**

Last Name:

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First Name:

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Medicaid ID Number:

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Date of Birth:

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Gender:  Male  Female

Weight in Kilograms: \_\_\_\_\_

**PRESCRIBER INFORMATION**

Last Name:

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First Name:

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NPI Number:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Phone Number:

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Fax Number:

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**DRUG INFORMATION**

Preferred Medications (Quantity Limits):

- Cinryze® – 20 vials per 34 days  Berinert® – 4 vials per attack (plus 4 for emergency)  
 icatibant: 1 dose per attack (plus 1 for emergency)  Sajazir™: 1 dose per attack (plus 1 for emergency)  
 Kalbitor® – 3 vials per attack (plus 3 for emergency) (see Black Box warning below)

**Because of the risk of anaphylaxis, KALBITOR® should only be administered by a healthcare professional with appropriate medical support to manage anaphylaxis and hereditary angioedema.**

Non-Preferred Medications (Quantity Limits):

- Firazyr®: 1 dose per attack (plus 1 for emergency)  Orladeyo®: 34 capsules per 34 days  
 Ruconest®: 2 vials per attack (plus 2 for emergency)  Takhzyro®: 2 vials per 28 days  
 Haegarda®: 2,000 IU SDV kit (16 kits per 28 days) and 3,000 IU SDV kit (8 kits per 28 days)

Drug Name/Form: \_\_\_\_\_

Strength: \_\_\_\_\_

Dosing Frequency: \_\_\_\_\_

Length of Therapy: \_\_\_\_\_

Quantity per Day: \_\_\_\_\_

(Form continued on next page.)

Member's Last Name:

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Member's First Name:

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**DIAGNOSIS AND MEDICAL INFORMATION**

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1. Has the recipient's diagnosis of HAE been confirmed by C1 inhibitor (C1-INh) deficiency or dysfunction (type 1 or 2 HAE) as documented by one of the following:

- C1-INh antigenic level below the lower limit of normal; **OR**
- C1-INh functional level below the lower limit of normal?

Yes     No

2. Was the medication prescribed by, or in consultation with, a specialist in allergy, immunology, hematology, pulmonology, or medical genetics?

Yes     No

**TREATMENT OF ACUTE HAE ATTACKS**

Berinert® (C1 esterase inhibitor), Firazyr® (icatibant), icatibant, Kalbitor® (ecallantide), Ruconest® (C1 esterase inhibitor), Sajazir™ (icatibant)

1. Will the requested medication be used as mono therapy to treat acute HAE attacks?

Yes     No

**PROPHYLAXIS OF HAE ATTACKS**

Cinryze® (C1 esterase inhibitor), Haegarda® (C1 esterase inhibitor), Orladeyo® (berotralstat), Takhzyro® (ianadelumab-flyo)

1. Will the requested medication be used for prophylaxis of HAE attacks?

Yes     No

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**Prescriber Signature (Required)**

**Date**

By signature, the physician confirms the above information is accurate and verifiable by member records.

**Please include ALL requested information; incomplete forms will delay the PA process.**

Submission of documentation does NOT guarantee coverage.