



Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.  
Hereditary Angioedema (HAE) Agents Prior Authorization (PA)  
Pharmacy Benefits Prior Authorization Help Desk  
Length of Authorizations: Initial- 1 year; Continuation- 1 year

**Instructions:**

This form is used by Kaiser Permanente and/or participating providers for coverage of **Hereditary Angioedema (HAE) Agents**. Please complete and fax this form back to Kaiser Permanente within 24 hours [fax: [1-866-331-2104](tel:1-866-331-2104)]. If you have any questions or concerns, please call [1-866-331-2103](tel:1-866-331-2103). **Requests will not be considered unless this form is complete. The KP-MAS Formulary can be found at: <http://pithelp.appl.kp.org/MAS/formulary.html>**

**1 – Patient Information**

Patient Name: \_\_\_\_\_ Kaiser Medical ID#: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**2 – Provider Information**

Is the provider a board-certified allergist, immunologist, or hematologist, or has the provider consulted with a specialist prior to prescribing?  No  Yes

Provider Name: \_\_\_\_\_ Provider NPI: \_\_\_\_\_

Provider Address: \_\_\_\_\_

Provider Phone #: \_\_\_\_\_ Provider Fax #: \_\_\_\_\_

Please check the boxes that apply:

Initial Request  Continuation of Therapy Request

Standard Review (72 hours)

Expedited Review (24 hours): By checking this box, I certify that applying 72 hours standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Provider Signature \_\_\_\_\_

**3 – Pharmacy Information**

Pharmacy Name: \_\_\_\_\_ Pharmacy NPI: \_\_\_\_\_

Pharmacy Phone # \_\_\_\_\_ Pharmacy Fax #: \_\_\_\_\_

**4 – Drug Therapy Requested**

Drug 1: Name/Strength/Formulation: \_\_\_\_\_

Sig: \_\_\_\_\_

Drug 2: Name/Strength/Formulation: \_\_\_\_\_

Sig: \_\_\_\_\_

**5 – Diagnosis**

Diagnosis: \_\_\_\_\_

**6 – Clinical Criteria**

**Requirement for prophylactic use:**

Patient must experience any of the following (select all that apply):

- HAE attacks that occur at least once monthly
- Patient is disabled at least 5 days per month
- Patient history of attacks with airway compromise or hospitalization
- Patient history of prior prophylaxis with Danazol (i.e. contraindicated, developed toxicity, diminished efficacy)

Prior pharmacological treatments used with outcomes:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please provide the clinical rationale as to why a preferred agent will not provide adequate benefit.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**7 – Provider Sign-Off**

**Additional Information – Please provide any additional information that should be taken into consideration.**

**I certify that the information provided is accurate. Supporting documentation is available for State audits.**

<b>Provider Signature:</b>	<b>Date:</b>
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