

Hereditary Angioedema (HAE) Prior Authorization/Reauthorization Checklist

Please note: Information provided is based upon top payer policies and should not be considered specific to one particular plan. Criteria listed are those that major payers most often require and are not intended to be a guide for diagnosing patients. Refer to payer plan for specific authorization requirements.

Laboratory Work

For initial authorization, you may be requested to provide current labs of the following, if available:

- C1-INH Antigenic Level: Below the lower limit of normal defined by lab performing test, or < 19 mg/dL
- C1-INH Functional Level/Percentage: Below the lower limit of normal defined by lab performing test, or < 50%
- C4 Level: Below the lower limit of normal defined by lab performing test, or < 14 mg/dL
- Genetic test confirming known C1-INH mutation (if available)

For reauthorization of existing patients, you may be requested to provide BOTH current AND pre-treatment labs of the tests listed above.

Patient Medical History

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| <ul style="list-style-type: none"> <input type="checkbox"/> History of HAE attacks <ul style="list-style-type: none"> • Duration • Severity • Frequency • Predictability (or lack thereof) • Sequelae of Attacks (ER visits, Hospitalization, Intubation) <input type="checkbox"/> Diagnosis of Hereditary Angioedema (ICD-10-CM) <ul style="list-style-type: none"> • D84.1: Defects in the complement system • C1-esterase inhibitor (C1-INH) deficiency | <ul style="list-style-type: none"> <input type="checkbox"/> Location <ul style="list-style-type: none"> • Abdomen • Extremities • Face • Larynx/Throat • Other | <ul style="list-style-type: none"> <input type="checkbox"/> Therapy History: previous failure, intolerance, or contraindication to other medications <ul style="list-style-type: none"> • Androgens • Antifibrinolytics • Other <input type="checkbox"/> Concurrent medications <ul style="list-style-type: none"> • If patient is on more than one acute HAE medication, provide rationale • Medications known to precipitate attack (eg, ACE-I, ARB, estrogens) have been evaluated and discontinued when appropriate |
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Demographic Background

- Patient Name, DOB, and Insurance information
- Weight, Dose, and Frequency (for prophylaxis)
- Family History of Hereditary Angioedema (if available)

Treatment Plan

Prophylactic Therapy: Include statement of rationale for use of prophylactic therapy, taking into account the angioedema attack frequency, severity, comorbid conditions, access to emergency treatment, patient job/career, and patient experience/preference.

- Provide dosage and frequency of administration
- Indicate your plan to discontinue any current prophylactic therapy
- If acute treatments will also be part of the plan, provide intended use of each treatment

Acute Treatment: Include statement of rationale for acute treatment and dosage. If other acute medications are being used, provide rationale for more than one acute treatment and intended use of each type of treatment.

Supplemental Documentation

- Statement of Medical Necessity Form
- Peer-reviewed articles and other documents supporting diagnosis/therapy
- Prescribing Information

Continued Treatment/ Reauthorization

Continuation or renewal of prophylactic therapy may require documentation of any or all of the following:

- Achieve and maintain at least a 50% reduction in the number of HAE attacks
- Achieve and maintain at least a 30% reduction in the duration of HAE attacks
- Achieve and maintain at least a 60% reduction in days of swelling

**For questions, please contact
CSL Behring's HAE Resource Hotlines:**

HAEGARDA
*Connect*SM

1-844-HAEGARDA (1-844-423-4273)

BERINERT
*Connect*SM

1-877-236-4423