

**HEREDITARY ANGIOEDEMA
PA FORM**



**Fax Completed Form to:
866-254-0761
For questions regarding this
Prior authorization, call
866-773-0695**

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a new prescription for an agent used to treat hereditary angioedema must meet the following criteria:

- **Patient must have diagnosis of hereditary angioedema confirmed by a specialist**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name		Recipient Date of Birth		Recipient Medicaid ID Number	
Physician Name			Specialist Involved in therapy:		
Physician Medicaid Provider Number		Telephone Number		Fax Number	
Address		City		State	Zip Code
Requested Drug and Dosage: <input type="checkbox"/> BERINERT <input type="checkbox"/> FIRAZYR <input type="checkbox"/> CINRYZE <input type="checkbox"/> KALBITOR		Diagnosis for this Request:			
<input type="checkbox"/> <i>I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.</i>					
Prescriber Signature				Date	

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:		
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #		

Part III: FOR OFFICIAL USE ONLY

Date Received	Initials:
Approved - Effective dates of PA: From: / / To: / /	Approved by:
Denied: (Reasons)	