# GEORGIA MEDICAID FEE-FOR-SERVICE
## HAE TREATMENTS PA SUMMARY

<table>
<thead>
<tr>
<th>Preferred</th>
<th>Non-Preferred</th>
</tr>
</thead>
<tbody>
<tr>
<td>Berinert (C1 esterase inhibitor [human])</td>
<td>Cinryze (C1 esterase inhibitor [human])</td>
</tr>
<tr>
<td>Firazyr (icatibant)</td>
<td>Kalbitor (ecallantide)^</td>
</tr>
<tr>
<td>Haegarda (C1 esterase inhibitor [human])</td>
<td>Ruconest (C1 esterase inhibitor [recombinant])</td>
</tr>
<tr>
<td>Icatibant generic</td>
<td>Takzyro (lanadelumab-flyo)</td>
</tr>
<tr>
<td>Orladeyo (berotralstat)*</td>
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</tbody>
</table>

*preferred but requires PA; ^non-preferred but does not require PA

**LENGTH OF AUTHORIZATION:** 1 year

**NOTES:**

- **The criteria details below are for the outpatient pharmacy program.** If a medication is being administered in a physician’s office or clinic, then the medication must be billed through the DCH physician services program and not the outpatient pharmacy program. Information regarding the physician services program is located at [www.mmis.georgia.gov](http://www.mmis.georgia.gov).
- Orladeyo is preferred but requires prior authorization. Kalbitor is non-preferred but does not require prior authorization.

**PA CRITERIA:**

**Orladeyo**

- Approvable for members 12 years of age or older with a diagnosis of hereditary angioedema (HAE) to prevent attacks who have experienced an inadequate response, allergy, contraindication, drug-drug interaction or intolerable side effect with Haegarda.

**Cinryze**

- Approvable for members 6 to 11 years of age with a diagnosis of HAE to prevent attacks who have experienced an inadequate response, allergy, contraindication, drug-drug interaction or intolerable side effect with Haegarda.
- Approvable for members 12 years of age or older with a diagnosis of HAE to prevent attacks who have experienced an inadequate response, allergies, contraindications, drug-drug interactions or intolerable side effects with Haegarda and Orladeyo.
- Approvable for members 18 years of age or older with a diagnosis of HAE for treatment of acute attacks who have experienced an inadequate response, allergies, contraindications, drug-drug interactions or intolerable side effects with Berinert and icatibant (Firazyr).

**Ruconest**

- Approvable for members 13 years of age or older with a diagnosis of HAE for treatment of acute attacks who have experienced an inadequate response, allergies, contraindications, drug-drug interactions or intolerable side effects with Berinert and icatibant (Firazyr).
Takhzyro

- Approvable for members 12 years of age or older with a diagnosis of HAE to prevent attacks who have experienced an inadequate response, allergies, contraindications, drug-drug interactions or intolerable side effects with Haegarda and Orladeyo.

EXCEPTIONS:

- Exceptions to these conditions of coverage are considered through the prior authorization process.
- The Prior Authorization process may be initiated by calling OptumRx at 1-866-525-5827.

PREFERRED DRUG LIST:

- For online access to the Preferred Drug List (PDL), please go to [http://dch.georgia.gov/preferred-drug-lists](http://dch.georgia.gov/preferred-drug-lists).

PA AND APPEAL PROCESS:

- For online access to the PA process, please go to [www.dch.georgia.gov/prior-authorization-process-and-criteria](http://www.dch.georgia.gov/prior-authorization-process-and-criteria) and click on Prior Authorization (PA) Request Process Guide.

QUANTITY LEVEL LIMITATIONS:

- For online access to the current Quantity Level Limits (QLL), please go to [www.mmis.georgia.gov/portal](http://www.mmis.georgia.gov/portal), highlight Pharmacy and click on Other Documents, then select the most recent quarters QLL list.