

**Louisiana Medicaid
Donidalorsen (Dawnzera™)**

The *Louisiana Uniform Prescription Drug Prior Authorization Form* should be utilized to request clinical authorization for donidalorsen (Dawnzera™).

Additional Point-of-Sale edits may apply.

By submitting the authorization request, the prescriber attests to the conditions available [HERE](#).

HAE Medication Use and Minimum Age per Current Drug-Specific Prescribing Information			
Medication	Brand	Use	Minimum Age
Donidalorsen	Dawnzera™	Prophylaxis	12

Approval Criteria for Initiation of Therapy

- The recipient has a diagnosis of hereditary angioedema (HAE); **AND**
- The recipient's age on the date of the request is not less than the minimum age recommended in the prescribing information (see table); **AND**
- The requested medication is used as recommended in the prescribing information for either prevention or treatment (see table); **AND**
- The prescriber **states on the request** that the requested medication is not prescribed concurrently with another medication for HAE prophylaxis; **AND**
- There is no preferred alternative that is the exact same chemical entity, formulation, strength, etc. **AND**
- If the request is for a non-preferred agent - **ONE** of the following is required: (See Hereditary Angioedema on the PDL/NPDL for list of preferred agents)
 - The recipient has had a *treatment failure* with at least one preferred drug that is appropriate to use for the condition being treated; **OR**
 - The recipient has had an *intolerable side effect* to at least one preferred drug that is appropriate to use for the condition being treated; **OR**
 - The recipient has *documented contraindication(s)* to the preferred drugs that are appropriate to use for the condition being treated; **OR**
 - There is *no preferred product that is appropriate* to use for the condition being treated.

Approval Criteria for Continuation of Therapy

- The prescriber **states on the request** that the recipient is established on the medication with evidence of a positive response to therapy; **AND**
- The prescriber **states on the request** that the requested medication is not prescribed concurrently with another medication for HAE prophylaxis.

Duration of approval for initiation and continuation of therapy: 12 months

Reference

Dawnzera (donidalorsen) [package insert]. Carlsbad, CA: Ionis Pharmaceuticals, Inc; August 2025.
<https://ionis.com/medicines/DAWNZERA/DAWNZERA-FPI.pdf>

Revision / Date	Implementation Date
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