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Pharmacy Policy

Hereditary Angioedema

Policy Number: 9.101
Revision Number: R1
Version Effective Date: 1/1/2021

Product Applicability	☐ **All Plan[+] Products**
Well Sense Health Plan ☒ New Hampshire Medicaid ☐ _____	**Boston Medical Center HealthNet Plan** ☐ MassHealth - MCO ☐ MassHealth - ACO ☐ Qualified Health Plans/ConnectorCare/Employer Choice Direct ☐ Senior Care Options ☐ _____

Note: Disclaimer and audit information is located at the end of this document.

Prior Authorization Policy

Products Affected:

- **Berinert (C1 Esterase Inhibitor [Human])**
- **Cinryze (C1 Esterase Inhibitor [Human])**
- **icatibant (Firazyr)**
- **Haegarda (C1 Esterase Inhibitor [Human])**
- **Kalbitor (ecallantide)**
- **Ruconest (C1 esterase inhibitor [recombinant])**
- **Takhzyro (lanadelumab-flyo)**

The Plan may authorize coverage of the above products for members meeting the following criteria:

Covered Use	All FDA approved indications not otherwise excluded
Exclusion Criteria	None
Required	Diagnosis and Documentation of the following:

[+] *Plan* refers to Boston Medical Center Health Plan, Inc. and its affiliates and subsidiaries offering health coverage plans to enrolled members. The Plan operates in Massachusetts under the trade name Boston Medical Center HealthNet Plan and in other states under the trade name Well Sense Health Plan.

Medical Information	1. Diagnosis of Hereditary Angioedema (HAE) 2. Attestation that genetic testing or laboratory results indicate normal C1q levels with C4 and C1 inhibitor levels below the limits of the laboratory's reference range; **AND** 3. Baseline frequency of HAE attacks must be documented; **AND** Treatment of HAE attacks require documentation of the following for **Berinert , icabitant Kalbitor, Ruconest:** 1. A history of acute facial, laryngeal, or gastrointestinal angioedema attacks due to HAE; **OR** Prophylactic treatment of HAE requires documentation of the following for **Cinryze, Haegarda, Takhzyro:** 1. An inadequate response, intolerance or contraindication to a trial of an attenuated androgen (e.g. danazol, oxandrolone, methyltestosterone); **OR** 2. Treatment is for a child who is less than Tanner Stage V (androgens are not recommended); **AND** 3. At least ONE of the following: a. More than one severe event per month b. More than 24 days per year affected by HAE **c.** History of a recurrent laryngeal attacks
Age Restriction	Berinert, Cinryze: 6 years of age and older Haegarda, Kalbitor, Ruconest, and Takhzyro: 12 years of age and older icabitant: 18 years of age and older
Prescriber Restriction	The prescriber must be a specialist in Allergy or Immunology
Coverage Duration	Initial: 3 months Reauthorization: 12 months
Other criteria	**Reauthorization:** **<u>Cinryze, Haegarda, and Takhzyro</u>** Documentation of the following: 1. Significant improvement in severity and duration of attacks have been achieved and sustained. **<u>Berinert, icabitant, Kalbitor, and Ruconest</u>** Documentation of the following: 1. Significant improvement in severity and duration of attacks have been achieved and sustained; **AND** 2. The member is receiving prophylactic therapy with attenuated androgens or a prophylactic HAE medication if the member has filled Berinert, icabitant, Kalbitor, or Ruconest more than once per month for 3 of the last 6 months (as evidenced by pharmacy claims); **AND** 3. Adherence to prophylactic therapy for HAE if applicable.

Applicable Coding:

Code	Medication
J0597	C1 esterase inhibitor (human), 10 units (Berinert®)- intravenous
J0598	C1 esterase inhibitor (human) 10 units (Cinryze™)- intravenous
J1290	Ecallantide 1mg (Kalbitor®)
J1744	Icantibant 1mg (Firazyr®)- subcutaneous
J0596	C1 esterase inhibitor (recombinant) Ruconest- intravenous
J0599	C1 esterase inhibitor (human) [Haegarda]- subcutaneous

Clinical Background Information and References

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2. Atkinson JP, Ciardi M, Zuraw B. Treatment of acute attacks in hereditary angioedema. UptoDate. Last updated Dec 19, 2014. Accessed February 2015. Available from http://www.uptodate.com.
3. Berinert® [package insert]. Kankakee (IL): CSL Behring LLC; September 2016.
4. Bowen T, et al. 2010 International Consensus Algorithm for the Diagnosis, Therapy, and Management of Hereditary Angioedema. *Allergy Asthma & Clinical Immunology.* 2010; 6:24. Available at: http://www.aacijournal.com/content/pdf/1710-1492-6-24.pdf.
5. Cicardi M, Zuraw B. Hereditary angioedema: General care and long-term prophylaxis. UpToDate. Last updated Aug 04,2015. Accessed February 2016. Available from http://www.uptodate.com
6. Cicardi M, Zuraw B. Hereditary angioedema: Treatment of acute attacks. UpToDate. Last updated Aug 04, 2015. Accessed February 2016. Available from http://www.uptodate.com.
7. Cinryze® [package insert]. Exton (PA): ViroPharma Biologics, Inc.; December 2016.
8. Craig, T., Aygören-Pürsün, E., & Maurer, M. (2012). WAO guideline for the management of hereditary angioedema. World Allergy Organ J, 5(12), 182-199.
9. Firazyr® [package insert]. Lexington (MA): Shire; December 2015.
10. Haegarda® [package insert]. Marburg, Germany: CSL Behring GmbH; October 2017.
11. Kalbitor® [package insert]. Burlington (MA): Dyax Corp.; March 2015.
12. Maurer M. et al. The International WAO/EAACI guideline for the management of hereditary angioedema- The 2017 revision and update. *Allergy*. 2018;73:1576-1596
13. Ruconest® [package insert]. Raleigh (NC): Santaris; February 2015.
14. Sardana N, Craig TJ. Recent Advances in Management and Treatment of Hereditary Angioedema. Pediatrics. 2011;128:1173-1180.
15. Takhzyro™ [package insert]. Lexington, MA; Dyax Corporation. August 2018
16. Zuraw B. Clinical Practice: Hereditary angioedema. *N Engl J Med*. 2008; 359(10):1027-36.
17. Zuraw BL, Banerji A, Bernstein JA, et al. US Hereditary Angioedema Association Medical Advistory Board 2013 recommendations for the management of hereditary angioedema due to C1 inhibitor deficiency. *J Allergy Clin Immunol Pract.* 2013;1(5):458-467.

Original Approval Date	Original Effective Date	Policy Owner	Approved by

12/1/2020	1/1/2021	Pharmacy Services	Pharmacy & Therapeutics (P&T) Committee, NH DHHS

Policy Revisions History			
Review Date	**Summary of Revisions**	**Revision Effective Date**	**Approved by**
12/1/2020	P&T Committee: discontinued policy 9.021 and created a separate policy for NH; reflected generic availability of Firazyr	1/1/2021	P&T Committee, NH DHHS

Next Review Date

2021

Other Applicable Policies

Reference to Applicable Laws and Regulations, If Any

Disclaimer Information

Medical Policies are the Plan's guidelines for determining the medical necessity of certain services or supplies for purposes of determining coverage. These Policies may also describe when a service or supply is considered experimental or investigational, or cosmetic. In making coverage decisions, the Plan uses these guidelines and other Plan Policies, as well as the Member's benefit document, and when appropriate, coordinates with the Member's health care Providers to consider the individual Member's health care needs.

Plan Policies are developed in accordance with applicable state and federal laws and regulations, and accrediting organization standards (including NCQA). Medical Policies are also developed, as appropriate, with consideration of the medical necessity definitions in various Plan products, review of current literature, consultation with practicing Providers in the Plan's service area who are medical experts in the particular field, and adherence to FDA and other government agency policies. Applicable state or federal mandates, as well as the Member's benefit document, take precedence over these guidelines. Policies are reviewed and updated on an annual basis, or more frequently as needed. Treating providers are solely responsible for the medical advice and treatment of Members.

The use of this Policy is neither a guarantee of payment nor a final prediction of how a specific claim(s) will be adjudicated. Reimbursement is based on many factors, including member eligibility and benefits on the date of service; medical necessity; utilization management guidelines (when applicable); coordination of benefits; adherence with applicable Plan policies and procedures; clinical coding criteria; claim editing logic; and the applicable Plan – Provider agreement.