

<b>Clinical Policy Title:</b>	C1 esterase Inhibitors
<b>Policy Number:</b>	RxA.070
<b>Drug(s) Applied:</b>	Haegarda®
<b>Original Policy Date:</b>	02/07/2020
<b>Last Review Date:</b>	12/11/2025
<b>Line of Business Policy Applies to:</b>	All lines of business (except Medicare)

## Criteria

### I. Initial Approval Criteria

#### A. Hereditary Angioedema (must meet all):

1. Diagnosis of HAE confirmed by one of the following (a or b):
  - a. Low C1-INH antigenic or functional level;
  - b. Normal C1-INH levels, and at least one of the following (i or ii):
    - i. Presence of a mutation associated with the disease;
    - ii. Recurring angioedema attacks that are refractory to high-dose antihistamine therapy (i.e., cetirizine 40 mg/day or equivalent) for at least 1 month.
2. Prescribed for the prophylaxis of HAE attacks.

#### Approval Duration

**All lines of business (Except Medicare):** 12 months

### II. Continued Therapy Approval

#### A. Hereditary Angioedema (must meet all):

1. Auto-approval based on lookback functionality within the past 120 days as a proxy for member responding positively to therapy

#### Approval Duration

**All lines of business (Except Medicare):** 12 months

## References

1. Bowen T, Cicardi M, Farkas H, et al. Canadian 2003 International Consensus Algorithm For the Diagnosis, Therapy, and Management of Hereditary Angioedema. *J Allergy Clin Immunol.* 2004 Sep;114(3):629-37. Available at: <https://pubmed.ncbi.nlm.nih.gov/15356569/>. Accessed September 4, 2024.
2. Craig T, Pursun E, Bork K, et al. WAO guideline for the management of hereditary angioedema. *WAO Journal.* 2012; 5: 182-199. Available at: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3651186/pdf/1939-4551-5-12-182.pdf>. Accessed September 4, 2024.
3. Zuraw BL, Banerji A, Bernstein JA, et al. US Hereditary Association Medical Advisory Board 2013 recommendations for the management of hereditary angioedema due to C1 inhibitor deficiency. *J Allergy Clin Immunol.* 2013; 1(5): 458-467. Available at: <https://pubmed.ncbi.nlm.nih.gov/24565617/>. Accessed September 4, 2024.
4. Zuraw BL, Bernstein JA, Lang DM, et al. A focused parameter update: hereditary angioedema, acquired C1 inhibitor deficiency, and angiotensin-converting enzyme inhibitor- associated angioedema. *J Allergy Clin Immunol.* 2013; 131(6): 1491-1493. Available at: <https://pubmed.ncbi.nlm.nih.gov/23726531/>. Accessed September 4, 2024.

This clinical policy has been developed to authorize, modify, or determine coverage for individuals with similar conditions. Specific care and treatment may vary depending on individual need and benefits covered by the plan. This policy is not intended to dictate to providers how to practice medicine, nor does it constitute a contract or guarantee regarding payment or results. This document may contain prescription brand name drugs that are trademarks of pharmaceutical manufacturers that are not affiliated with RxAdvance.

September 4, 2024.

Review/Revision History	Review/Revised Date	P&T Approval Date
Policy established.	01/2020	02/07/2020
1. Updated References.	05/2020	05/21/2020
<p>Policy was reviewed:</p> <ol style="list-style-type: none"> <li>1) Initial Therapy Criteria I.A.3.c was removed and clubbed with A.3.b. and age for Ruconest® was updated from age ≥ 13 to age ≥ 12.</li> <li>2) Continuation therapy criteria II.A.1. rephrased to “Member is currently receiving medication that has been authorized by RxAdvance or the member has met initial approval criteria listed in this policy</li> <li>3) Initial therapy and continued therapy approval duration updated from Duration of request or 3 months (Whichever is less) to “3 months”</li> <li>4) Deleted HIM from Approval duration</li> <li>5) References were updated.</li> </ol>	01/20/2021	03/09/2021
<p>Policy was reviewed:</p> <ol style="list-style-type: none"> <li>1) Initial Approval Criteria I.A.4.c was removed.</li> <li>2) I.a.6.a,I.A.6.c , II.B.4.a and II.B.4.c was updated to remove” up to 2 administered in a 24-hour period”.</li> <li>3) Initial and continued therapy approval duration updated to remove short term prophylaxis.</li> <li>4) References were reviewed and updated.</li> </ol>	11/22/2021	01/17/2022
<p>Policy was reviewed:</p> <ol style="list-style-type: none"> <li>1. Initial Approval Criteria, I.A.1: Updated diagnostic criteria from Diagnosis of HAE confirmed by one of the following to Diagnosis of HAE confirmed by a history of recurrent angioedema and one of the following.</li> <li>2. Initial Approval Criteria, I.A.1.b.i: Updated diagnostic criteria from History of recurrent angioedema to Presence of a mutation associated with the disease (see Appendix D).</li> <li>3. Initial Approval Criteria, I.A.1.b.ii: Updated diagnostic criteria from Family history of angioedema to Family history of angioedema and documented failure of high-dose antihistamine therapy (i.e., cetirizine 40 mg/day or equivalent) for at least 1 month or an interval expected to be associated with 3 or more attacks of angioedema, whichever is longer.</li> <li>4. Initial Approval Criteria, I.A.4.a: Updated dosing criteria from For treatment of acute HAE attacks,</li> </ol>	09/30/2022	01/17/2023

<p>meets one of the following to For treatment of acute HAE attacks, request does not exceed 4 doses per month and meets one of the following.</p> <ol style="list-style-type: none"> <li>5. Initial Approval Criteria, I.A.4.b: Updated diagnostic criteria from For prophylaxis of HAE attacks, meets all of the following to For long-term prophylaxis of HAE attacks, meets all of the following.</li> <li>6. Initial Approval Criteria, I.A.4.c: Updated to include new diagnostic criteria For short-term prophylaxis of HAE attacks, both of the following (i and ii):             <ol style="list-style-type: none"> <li>i. Member requires major dental work or surgical procedure;</li> <li>ii. Request does not exceed 2 doses per procedure.</li> </ol> </li> <li>7. Intitial Therapy Approval Crtieria, I.A: Updated to include new approval criteria Short-term prophylaxis: 4 weeks (no more than 2 doses per procedure).</li> <li>8. Intitial Therapy Approval Crtieria, I.A: Updated approval duration criteria for Treatment of HAE attacks: from Medicaid: 12 months to Medicaid: 6 months.</li> <li>9. Initial Therapy Approval Crtieria, I.A: Updated approval duration criteria for Prophylaxis: Commercial: 6 months Medicaid: 12 months to Long-term prophylaxis: Commercial: 6 months Medicaid: 6 months.</li> <li>10. Continued Therapy Approval, II.A.4: Updated to include new dosing criteria For treatment of acute attacks, request does not exceed 4 doses per month.</li> <li>11. Continued Therapy Approval, II.A.5.a: Updated dosing criteria from Berinert®: 20 IU/kg of body weight per single dose to Berinert®: 20 IU/kg of body weight per single dose, up to 2 doses administered in a 24-hour period.</li> <li>12. Continued Therapy Approval, II.A.5.d: Updated dosing criteria from Ruconest®: 4,200 U per single dose, up to 2 doses administered in a 24-hour period to Ruconest®: 4,200 U per single dose, up to 2 doses administered in a 24-hour period, up to 2 doses administered in a 24-hour period.</li> <li>13. Continued Therapy Approval, II.A: Updated approval duration criteria Prophylaxis to Long-term Prophylaxis.</li> </ol>		
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14. References were reviewed and updated.		
Policy was reviewed.	10/19/2023	10/19/2023
Policy was reviewed: 1. Removed Berinert, Cinryze, and Ruconest from policy.	03/15/2024	02/28/2024
Policy was reviewed: 1. Age, dosing, and prescriber requirements were removed. 2. References were reviewed and updated.	09/04/2024	09/13/2024
Policy was reviewed:	12/11/2025	12/11/2025