Clinical Policy Title:	c1 esterase Inhibitors
Policy Number:	RxA.070
Drug(s) Applied:	Haegarda®
Original Policy Date:	02/07/2020
Last Review Date:	09/04/2024
Line of Business Policy Applies to:	All lines of business (except Medicare)

Criteria

I. Initial Approval Criteria

A. Hereditary Angioedema (must meet all):

1. Diagnosis of HAE confirmed by a history of recurrent angioedema and one of the following (a or b):
   a. Low C4 level and low C1-INH antigenic or functional level;
   b. Normal C4 level and normal C1-INH levels, and at least one of the following (i or ii):
      i. Presence of a mutation associated with the disease;
      ii. 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;
2. Member meets one of the following (a or b):
   a. For long-term prophylaxis of HAE attacks, meets the following (i and ii):
      i. Member experiences more than one severe event per month OR is disabled more than five days per month OR has a history of previous airway compromise;
   b. For short-term prophylaxis of HAE attacks, both of the following (i and ii):
      i. Member requires major dental work or surgical procedure;
      ii. Request does not exceed 2 doses per procedure;
3. Member is not concomitantly using the requested product with another FDA-approved product for the same indication.

Approval Duration
All lines of business (Except Medicare)
Short-term prophylaxis: 4 weeks (no more than 2 doses per procedure)
Treatment of acute attacks: 6 months
Long-term prophylaxis: 6 months

II. Continued Therapy Approval

A. All Indications in Section I (must meet all):

1. Member is currently receiving or has been treated with this medication within the past 120 days, excluding manufacturer samples;
2. Member is responding positively to therapy (e.g., if Haegarda® are requested for long-term prophylaxis, member has demonstrated a reduction in attacks from baseline, or request is for a dose increase);
3. Member is not using the requested product concomitantly with another FDA- approved product for the same indication.

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.

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
Policy was reviewed: 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. 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 3) Initial therapy and continued therapy approval duration updated from Duration of request or 3 months (Whichever is less) to "3 months" 4) Deleted HIM from Approval duration 5) References were updated.	01/20/2021	03/09/2021
Policy was reviewed: 1) Initial Approval Criteria I.A.4.c was removed. 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". 3) Initial and continued therapy approval duration updated to remove short term prophylaxis. 4) References were reviewed and updated.	11/22/2021	01/17/2022
Policy was reviewed: 1. Initial Approval Criteria, I.A.1: Updated diagnostic criteria from Diagnosis of HAE confirmed by one	09/30/2022	01/17/2023

of the following to Diagnosis of HAE confirmed by a history of recurrent angioedema and one of the following. 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). 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. 4. Initial Approval Criteria, I.A.4.a: Updated dosing criteria from For treatment of acute HAE attacks, 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. 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. 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): i. Member requires major dental work or surgical procedure; ii. Request does not exceed 2 doses per procedure. 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). 8. Intitial Therapy Approval Crtieria, I.A: Updated approval duration criteria for Treatment of HAE attacks: from Medicaid: 12 months to Medicaid: 6 months. 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. 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. 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. 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. 13. Continued Therapy Approval, II.A: Updated approval duration criteria Prophylaxis to Long-term Prophylaxis. 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