

## Medical Policy



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Blue Cross Blue Shield Association

**Title: Hereditary Angioedema  
(Berinert, Cinryze, Firazyr, Kalbitor, Ruconest)**

- **Prime Therapeutics will review Prior Authorization requests.**

**Prior Authorization Form:**

<http://www.bcbsks.com/CustomService/Forms/pdf/PriorAuth-Hereditary-Angioedema.pdf>

**Link to Drug List (Formulary):**

[http://www.bcbsks.com/CustomService/PrescriptionDrugs/drug\\_list.shtml](http://www.bcbsks.com/CustomService/PrescriptionDrugs/drug_list.shtml)

### **Professional**

Original Effective Date: April 1, 2014  
Revision Date(s): April 1, 2014;  
April 24, 2014; May 1, 2015; May 1, 2016;  
April 1, 2017  
Current Effective Date: May 1, 2016

### **Institutional**

Original Effective Date: April 1, 2014  
Revision Date(s): April 1, 2014;  
April 24, 2014; May 1, 2015; May 1, 2016;  
April 1, 2017  
Current Effective Date: May 1, 2016

**State and Federal mandates and health plan member contract language, including specific provisions/exclusions, take precedence over Medical Policy and must be considered first in determining eligibility for coverage. To verify a member's benefits, contact [Blue Cross and Blue Shield of Kansas Customer Service](#).**

**The BCBSKS Medical Policies contained herein are for informational purposes and apply only to members who have health insurance through BCBSKS or who are covered by a self-insured group plan administered by BCBSKS. Medical Policy for FEP members is subject to FEP medical policy which may differ from BCBSKS Medical Policy.**

**The medical policies do not constitute medical advice or medical care. Treating health care providers are independent contractors and are neither employees nor agents of Blue Cross and Blue Shield of Kansas and are solely responsible for diagnosis, treatment and medical advice.**

**If your patient is covered under a different Blue Cross and Blue Shield plan, please refer to the Medical Policies of that plan.**

### **DESCRIPTION**

The intent of the Hereditary Angioedema (HAE) medical drug criteria is to ensure appropriate selection of patients for treatment according to product labeling and/or

clinical studies and/or guidelines and according to dosing recommended in product labeling. The policy will consider these agents appropriate for patients with FDA labeled indication(s) or indications supported in clinical studies and/or clinical guidelines. Dosing will be limited to the FDA labeled or clinically supported dosage for the specific indication. Utilization of more than one agent approved to treat acute attacks will not be supported.

### Target Drugs

- **Berinert** (C1 Esterase Inhibitor [human])
- **Cinryze** (C1 Esterase Inhibitor [human])
- **Firazyr** (icatibant)
- **Kalbitor** (ecallantide)
- **Ruconest** (C1 Esterase Inhibitor [recombinant])

### FDA Approved Products for Acute Attacks and Routine Prophylaxis of Hereditary Angioedema (HAE) <sup>1-5</sup>

Medication	Indications	Recommended Dose
<b>Berinert</b> (C1 esterase inhibitor [human])	Treatment of acute abdominal, facial, or laryngeal hereditary angioedema (HAE) in adult and pediatric patients.  Safety and efficacy for prophylactic therapy have not been established.	20 IU/kg IV administered at 4 mL/minute. Supplied as 500 IU in 10 mL  Patient may self-administer
<b>Cinryze</b> (C1 esterase inhibitor [human])	Treatment for routine prophylaxis against angioedema attacks in adolescent and adult patients with HAE.	1,000 Units IV administered at 1 mL/min every 3 to 4 days  Patient may self-administer
<b>Firazyr</b> (icatibant)	Treatment of acute attacks of HAE in adults 18 years of age and older.	30 mg SQ in abdominal area. Additional doses may be given at least 6 hours apart up to a maximum of 3 doses in a 24 hour period.  Patient may self-administer
<b>Kalbitor</b> (ecallantide)	Treatment of acute attacks of HAE in patients 12 years of age and older	30 mg (3 mL) administered subcutaneously in three 10 mg (1 mL) injections. If the attack persists, an additional dose of 30 mg may be administered within a 24 hour period.  Must be administered by a health care provider.
<b>Ruconest</b> (C1 esterase inhibitor, recombinant)	Treatment of acute attacks of HAE in adults and adolescents  Limitation of Use: Effectiveness was not established in HAE patients with laryngeal attacks.	50 IU/kg (maximum dose 4200 IU) administered via slow intravenous infusion over approximately five minutes. A second dose may be administered if symptoms persist. (maximum 2 doses in 24 hours).  Patient may self-administer.

**POLICY****Prior Authorization and Quantity Limits Criteria for Approval****Berinert, Firazyr, Kalbitor, or Ruconest****Initial Evaluation**

**Berinert, Firazyr, Kalbitor or Ruconest** will be approved when the following are met:

1. The patient does not have any FDA labeled contraindications to therapy  
**AND**
2. ONE of the following:
  - a. If the client has grandfathering, there is documentation that the patient is already being treated with the requested agent  
**OR**
  - b. If the client does not have grandfathering or does have grandfathering but the patient is not currently on the medication, the patient has a diagnosis of Type I or Type II hereditary angioedema (HAE) evidenced by ONE of the following:
    - i. BOTH of the following (there must be TWO separate low measurements for each test defined as below the testing laboratory's lower limit of the normal range):
      - a) Low Serum complement factor 4 (C4) level  
**AND**
      - b) EITHER Low C1-INH antigenic level **OR** Low C1-INH functional  
**OR**
    - ii. The patient has a mutation in the C1INH gene altering protein synthesis and/or function  
**AND**
3. Medications known to cause angioedema (i.e. ACE-Inhibitors, estrogens, angiotensin II receptor blockers) have been evaluated and discontinued when appropriate  
**AND**
4. The requested agent will be used to treat HAE acute attacks  
**AND**
5. The patient is receiving only ONE agent indicated for treatment of acute HAE attacks  
**AND**
6. ONE of the following:
  - a. The dose is within the program quantity limit (allows for 2 acute attacks per month)  
**OR**

- b. The quantity (dose) requested is greater than the program quantity limit and prescriber has submitted documentation (e.g. frequency of attacks within the past 3 months has been >2 attacks per month) in support of therapy with a higher quantity which has been reviewed and approved

**Length of Approval:** 6 months

### **Renewal Criteria**

1. The patient has been previously approved for therapy through the Prime Therapeutics Medical Drug Review process  
**AND**
2. The patient is receiving only ONE agent indicated for treatment of acute HAE attacks  
**AND**
3. The prescriber has submitted documentation that the patient continues to have acute HAE attacks  
**AND**
4. The prescriber has communicated (via any means) with the patient regarding frequency and severity of attacks and has verified that the patient does not have >1 month supply (sufficient for 2 acute attacks) currently on-hand  
**AND**
5. The patient does not have any FDA labeled contraindications to therapy  
**AND**
6. ONE of the following:
  - a. The dose is within the program quantity limit (quantity limits allow for 2 acute attacks per month)  
**OR**
  - b. The quantity (dose) requested is greater than the program quantity limit and prescriber has submitted documentation (e.g. frequency of attacks within the past 3 months has been >2 attacks per month) in support of therapy with a higher quantity which has been reviewed and approved

**Length of Approval:** 12 months

**Cinryze****Initial Evaluation**

**Cinryze** will be approved when the following are met:

1. The patient does not have any FDA labeled contraindications to therapy  
**AND**
2. If the client has grandfathering, there is documentation that the patient is already being treated with the requested agent **AND** the following:
  - a. If the agent is prescribed for acute HAE attacks, then the patient is receiving only ONE target agent indicated for treatment of acute HAE attacks  
**AND**
3. If the client does not have grandfathering or does have grandfathering but the patient is not currently on the medication, ALL of the following:
  - a. The patient has a diagnosis of Type I or Type II hereditary angioedema (HAE) evidenced by one of the following:
    - i. BOTH of the following (there must be TWO separate low measurements for each test defined as below the testing laboratory's lower limit of the normal):
      - a) Low Serum complement factor 4 (C4) level  
**AND**
      - b) EITHER Low C1-INH antigenic level **OR** Low C1-INH functional  
**OR**
    - ii. The patient has a mutation in the C1INH gene altering protein synthesis and/or function  
**AND**
  - b. ONE of the following:
    - i. The requested agent will be used to treat HAE acute attacks **AND** the following:
      - a) The patient is receiving only ONE agent indicated for treatment of acute HAE attacks  
**OR**
    - ii. The agent will be used for prophylaxis and BOTH of the following:
      - a) The patient has had at least 2 acute severe (e.g. swelling of throat, incapacitating abdominal or cutaneous swelling) attacks per month  
**AND**
      - b) ONE of the following:
        - 1) the patient has tried and failed danazol, aminocaproic acid, or tranexamic acid  
**OR**
        - 2) The patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to danazol, aminocaproic acid, or tranexamic acid

**AND**

4. Medications known to cause angioedema (i.e. ACE-Inhibitors, estrogens, angiotensin II receptor blockers) have been evaluated and discontinued when appropriate  
**AND**
5. ONE of the following:
  - a. The dose is within the FDA labeled or clinically supported dose and within the quantity limit  
**OR**
  - b. The quantity (dose) requested is greater than the program quantity limit and prescriber has submitted documentation in support of therapy with a higher quantity which has been reviewed and approved

**Length of Approval:** 3 months

### **Renewal Criteria**

1. The patient has been previously approved for therapy through the Prime Therapeutics Medical Drug Review process  
**AND**
2. ONE of the following:
  - a. The requested agent was initially approved for acute HAE attacks and ALL of the following:
    - i. The patient is receiving only ONE agent indicated for treatment of acute HAE attacks  
**AND**
    - ii. The prescriber has submitted documentation that the patient continues to have acute HAE attacks  
**AND**
    - iii. The prescriber has communicated (via any means) with the patient regarding frequency and severity of attacks and has verified that the patient does not have >1 month supply (sufficient for 2 acute attacks) currently on-hand  
**OR**
  - b. The requested agent was initially approved for prophylaxis of HAE attacks and the following:
    - i. The patient has had a decrease in the frequency of acute attacks from baseline (prior to treatment)  
**AND**
3. The patient has does not have any FDA labeled contraindications to therapy  
**AND**
4. ONE of the following
  - a. The dose is within the FDA labeled dose or clinically supported dose and within the quantity limit  
**OR**

- b. The quantity (dose) requested is greater than the program quantity limit and prescriber has submitted documentation in support of therapy with a higher quantity which has been reviewed and approved

**Length of Approval:** 12 months

Agent <sup>1-4,12</sup>	Contraindications
<b>Berinert</b> (C1 Esterase Inhibitor [human])	Patients with history of life-threatening hypersensitivity reactions, including anaphylaxis, to C1 esterase inhibitor preparations
<b>Cinryze</b> (C1 Esterase Inhibitor [human])	Patients who have manifested life-threatening immediate hypersensitivity reactions, including anaphylaxis, to the product
<b>Firazyr</b> (icatibant)	None
<b>Kalbitor</b> (ecallantide)	Patients with known hypersensitivity to ecallantide
<b>Ruconest</b> (C1 Esterase Inhibitor [recombinant])	Patients with suspected allergy to rabbits and rabbit-derived products; patients with history of immediate hypersensitivity reactions, including anaphylaxis, to C1 esterase inhibitor preparations

Brand (generic)	Quantity Limit
<b>Berinert</b> <sup>®</sup> (C1 Esterase Inhibitor [Human])	
500 International Units/ 10 mL	5,000 International Units (10 vials)/30 days*
<b>Cinryze</b> <sup>®</sup> (C1 Esterase Inhibitor [Human])	
500 Units/ 10 mL	10,000 Units (20 vials)/30 days*
<b>Firazyr</b> <sup>®</sup> (icatibant)	
30 mg/3 mL syringe	6 syringes/30 days
<b>Kalbitor</b> <sup>®</sup> (ecallantide)	
3 - 10 mg/mL single use vials	4 kits 30 days
<b>Ruconest</b> <sup>®</sup> (C1 Esterase Inhibitor [recombinant])	
2100 International Unit single use vials	8 vials / 30 days*

\*calculation based on CDC 90 percentile for weight in adults and averaged for men and women to 238 lbs (108 kg).

## **RATIONALE**<sup>4,6-14</sup>

Hereditary Angioedema (HAE) is an autosomal dominant disease occurring in approximately 1 in 50,000 persons without known differences between the sexes or ethnic groups. It is characterized by recurrent episodes/attacks of nonpruritic, nonpitting, subcutaneous or submucosal edema that may involve the extremities, bowels, genitalia, trunk, face, tongue, or larynx. Attacks result in progressive swelling without erythema over the first 24 hours and then the swelling gradually subsides during the following 48 to 72 hours. Symptoms of HAE typically begin in the first or second decade of life and persist throughout; however, any acute attack has the potential to be life-threatening. An acute attack that causes death is most often a result of abdominal or laryngeal involvement. Triggers for attacks vary and may be traceable to a source (e.g. minor trauma or stress); however, episodes often occur without a defined precipitating factor.

Three types of HAE have been identified. Type I accounts for approximately 85% of all cases and is characterized by deficient levels of C1 esterase inhibitor (C1-INH) protein. This is in contrast to Type II (approximately 15% of all cases) where a normal level of C1-INH protein is found, but there is diminished C1-INH activity (i.e. dysfunctional C1-INH protein). Type III HAE, characterized by both normal C1-INH protein and functional levels, is rare.

Types I and II occur as a result of a mutation in the SERPING1 gene that codes for C1-INH and ultimately leads to the increased generation of bradykinin. Bradykinin has been credited in all types for involvement in attacks through increasing vascular permeability via the B2 receptor. Although Type III pathophysiology has not been fully elucidated, mutations in coagulation factor XII and effects of estrogen that affect bradykinin have been associated. The US HAE Association Medical Advisory Board (2013) recommends that current medications that affect bradykinin and can cause angioedema (e.g. angiotensin converting-enzyme inhibitors and estrogen replacement) be evaluated and stopped when appropriate.

In addition to clinical presentation and an assessment of family history, HAE diagnosis typically includes a laboratory workup of C4, C1-INH antigenic level, and C1-INH function. C4, the natural substrate for C1 esterase, is considered the single best screening test for C1-INH deficiency. At least 95% of patients with C1-INH deficiency will always have a reduced C4 even between attacks. If the patient has a normal C4, repeating the C4 during an attack increases the probability (nearly 100% of patients) that the patient's C4 will be low. In order to further distinguish between Type I and Type II HAE, the C1-INH antigenic level and/or functional activity is measured. It is recommended to repeat the blood tests to confirm diagnosis.

Prior to C1 inhibitors, icatibant, and ecallantide, treatment of acute attacks involved fresh frozen plasma and fluid/ventilation support. Currently, clinical evidence supporting the use of more than one agent used to treat acute attacks at the same time is lacking. For patients requiring prophylaxis, there are medications that are considered beneficial. Danazol and other 17 alpha-alkylated androgens have been used for long term prophylaxis with success and are still recommended for use. However, androgens have undesirable side effects (e.g. liver toxicity) and have limited use in pregnancy. Beyond 17 alpha-alkylated androgens, Cinryze (C1 esterase inhibitor, [human]) is approved in the U.S. for routine prophylaxis against angioedema attacks in adolescent and adult patients with HAE. The pivotal clinical trials required patients to have at least 2 HAE attacks per month prior to moving to prophylaxis. Guidelines recommend Cinryze as first-line long term prophylaxis (LTP) for pregnant or lactating HAE patients. Outside of the United States aminocaproic acid and tranexamic acid are approved for long-term prophylaxis of HAE.

\*Pivotal clinical trial data for each of the products can be accessed in the prescribing information

### **Safety**<sup>1-5</sup>

C1 esterase inhibitor products [(human-Beriner, Cinryze); (recombinant-Ruconest)] are contraindicated in patients who have experienced life-threatening hypersensitivity reactions, including anaphylaxis, to C1-INH preparations. Serious hypersensitivity reactions, including anaphylaxis may occur. Epinephrine should be immediately available for treatment of acute hypersensitivity reactions. Since Ruconest is made from the milk of transgenic rabbits, its use is contraindicated in patients with allergies to rabbits or rabbit derived products. Thrombotic events



have been reported following administration of C1-INH products when used off-label at higher than labeled doses.

Anaphylaxis has been reported after administration of ecallantide (Kalbitor). The prescribing information contains a boxed warning for this, and it requires administration by a healthcare professional with appropriate medical support. Anaphylaxis occurred in 3.9% of treated patients in clinical trials.

Given the potential for airway obstruction during acute laryngeal HAE attacks, patients should be advised to seek medical attention in an appropriate healthcare facility immediately in addition to treatment with Berinert, Firazyr, or Kalbitor.

\*Further safety information for each agent can be found by accessing the agent's specific prescribing information.

### **Guidelines**<sup>8-14</sup>

Consensus guidelines from HAE International Working Group recommend with a high level of evidence that all patients have access to at least one of the plasma-derived/recombinant C1-INHs, icatibant, or ecallantide. They also recommend that patients should have on-demand medicine to treat acute attacks at home and should be trained to self-administer when possible and supported by product labeling. Additionally, several guidelines note that some patients will need long term prophylaxis (LTP) in addition to on demand treatment.

A focused parameter update developed by a joint task force representing the American Academy of Allergy, Asthma & Immunology (AAAAI), the American College of Allergy, Asthma & Immunology (ACAAI), and the Joint Council of Allergy, Asthma and Immunology (2013) supports:

- HAE attacks: symptomatic treatment, efficacy of fresh frozen plasma often, and safety and efficacy of C1-INHs, plasma kallikrein inhibitor, or bradykinin B2 receptor antagonist.
- HAE Prophylaxis: anabolic androgens as effective and relatively safe; antifibrinolytic agents as somewhat effective and relatively safe but generically less effective than androgens; and C1-INH as safe and effective.

An international consensus from AAAAI, ACAAI, WAO, and the European Association of Allergy and Clinical Immunology recommend the following:

- HAE attacks: C1-INH, ecallantide, and icatibant are all efficacious and safe; fresh frozen plasma should be used when no other treatments are available.
- HAE prophylaxis: patients not treated successfully with on-demand therapy should be considered for long-term prophylaxis. C1-INH is effective; 17 alpha-alkylated androgens may decrease frequency and severity of HAE attacks but have potential adverse effects if used long term; antifibrinolytic agents have been used but are less effective.

US HAE Association Medical Advisory Board 2013 recommends:

- HAE attacks: early treatment of acute attacks with C1-INH, ecallantide, icatibant, or fresh frozen plasma. The medication selection should be individualized based on patient response and all attacks should be considered for treatment irrespective of anatomical location. Patients should have access to at least two doses of medicine for on-demand treatment of acute attacks.

- HAE prophylaxis: the decision to initiate long term prophylaxis should be individualized and consider attack severity, frequency, comorbid conditions, and patient experience/preference. Medication options include C1-INH as well as older alternatives of danazol, stanozolol, orandralone, methyl-testosterone, aminocaproic acid, or tranexamic acid. Short term prophylaxis with C1-INH or anabolic androgens may be indicated before medical, surgical, or dental procedures.
- Attack frequency and severity should be evaluated by the physician on an ongoing basis. The US HAEA MAB recommends that patients keep a record of all of their attacks, regardless of severity (mild, moderate, or severe). These logs or attack records should be maintained in a format (e.g., electronic, paper) that is decided upon between the patient and physician and is easy for the patient to complete. Regardless of format, these records should specifically identify the following 3 domains: description of attack, treatment of attack, and response to treatment. Physician knowledge of the patient's HAE attack frequency and severity is critical to determine the ongoing management of HAE. Data captured from the attack logs are considered vital information to be documented in the patient's medical records. This attack diary should be provided to the treating physicians and reviewed on a regular basis by a means (i.e., in person or electronically) predetermined between the patient and the physician.
- Physician knowledge of when patients may require and when they have administered on-demand treatment is a key aspect of optimal management of HAE and highlights the importance of a strong patient-physician partnership and communication. When patients self-administer or receive on-demand medications, there must be a plan to have the patient report this use in a timely manner, as discussed above. The MAB recommends that potential triggers of HAE be reviewed when patients come into the office for visits. This includes an updated list of current medications to ensure that patients are not taking an angiotensin-converting enzyme inhibitor or estrogen replacement. For patients who are well controlled, return visits may occur once every 6-12 months.

## REVISIONS

04-01-2014	Policy added to the bcbsks.com web site on 02-28-2014 for an effective date of 04-01-2014.
04-24-2014	Link to Prior Authorization form added.
05-01-2015	Policy published 03-31-2015.
	Title updated adding "Ruconest", to read, "Hereditary Angioedema (Berinert, Cinryze, Firazyr, Kalbitor, Ruconest)"
	Description section updated to include adding Ruconest to Target Drugs and updating FDA Approved Indications and Dosage chart.
	In Policy section: <ul style="list-style-type: none"> <li>▪ Policy updated to current language from:  "Initial Criteria  Berinert, Firazyr, or Kalbitor will be approved when the following are met:  1. The patient does not have any FDA labeled contraindications to therapy   AND  2. ALL of the following:  a. The patient has a diagnosis of hereditary angioedema (HAE) which has been diagnosed with measurement of C1-INH antigenic level, C1-INH functional level, and C4 level   AND  b. The requested agent will be used to treat HAE acute attacks   AND  3. The dose is within the FDA labeled dose</li> </ul>

	<p>Length of Approval: 12 months"                  And                  "Renewal Criteria                  1. The patient has been previously approved for therapy through Prime Therapeutics Medical Drug Review process AND                  2. The patient has received benefit from use of the requested agent to treat HAE acute attacks AND                  3. The patient does not have any FDA labeled contraindications to therapy AND                  4. The dose is within the FDA labeled dose                  Length of Approval: 12 months"                  And                  "Initial Criteria                  Cinryze will be approved when the following are met:                  1. The patient does not have any FDA labeled contraindications to therapy AND                  2. ALL of the following:                      a. The patient has a diagnosis of hereditary angioedema (HAE) which has been diagnosed with measurement of C1-INH antigenic level, C1-INH functional level, and C4 level AND                      b. ONE of the following:                          i. The requested agent will be used to treat HAE acute attacks OR                          ii. The requested agent will be used for prophylaxis against HAE attacks AND the patient has tried danazol or has a documented intolerance, FDA labeled contraindication, or hypersensitivity to danazol AND                  3. The patient has a history of at least 2 acute HAE attacks per month AND                  4. The dose is within the FDA labeled or clinically supported dose                  Length of Approval: 12 months"                  And                  "Renewal Criteria                  1. The patient has been previously approved for therapy through Prime Therapeutics Medical Drug Review process AND                  2. The patient has received benefit from use of the requested agent to prevent or treat HAE acute attacks AND                  3. The patient has does not have any FDA labeled contraindications to therapy AND                  4. The dose is within the FDA labeled dose                  Length of Approval: 12 months"                  ▪ Contraindications and Program Quantity Limits charts updated and Reconest added                  Rationale section updated                  Coding section removed                  References updated</p>
<p>05-01-2016</p>	<p>Policy published 03-31-2016. Policy effective 05-01-2016.                  Description section updated to include updates to the FDA Indications and Dosage chart.                  In Policy section:  <u>Initial Criteria Berinert, Firazyr, Kalbitor, or Ruconest</u>                  ▪ In Item 2 changed "ALL" to "ONE"                  ▪ Added 2 a "If the client has grandfathering, there is documentation that the patient is already being treated with the requested agent "                  ▪ In Item 2 b added "If the client does not have grandfathering or does have grandfathering but the patient is not currently on the medication" and "evidenced by ONE of the following" to read "If the client does not have grandfathering or does have grandfathering but the patient is not currently on the medication, the patient has a diagnosis of Type I or Type II hereditary angioedema (HAE) evidenced by ONE of the following:"                  ▪ In Item 2 b i added "BOTH of the following (there must be", "low", "for each test" and</p>

	<p>removed "of TWO of the following labs", "or by the following specific lab value)" to read "BOTH of the following (there must be TWO separate low measurements for each test defined as below the testing laboratory's lower limit of the normal range):"</p> <ul style="list-style-type: none"> <li>▪ In Item 2 b i a) revised "C4 level less than 20 mg/dL (range 20-58 mg/dL)" to read "Low Serum complement factor 4 (C4) level"</li> <li>▪ In Item 2 b i b) revised "C1-INH functional level less than 68% (normal <math>\geq</math> 68%) OR C4 level less than 20 mg/dL (range 20-58 mg/dL)" to read "EITHER Low C1-INH antigenic level OR Low C1-INH functional"</li> <li>▪ Added 2 b ii "The patient has a mutation in the C1INH gene altering protein synthesis and/or function"</li> <li>▪ In Length of Approved revised from "12 months" to "6 months"</li> </ul> <p><u>Renewal Criteria Berinert, Firazyr, Kalbitor, or Ruconest</u></p> <ul style="list-style-type: none"> <li>▪ Added Item 2 "The patient is receiving only ONE agent indicated for treatment of acute HAE attacks"</li> <li>▪ Added Item 3 "The prescriber has submitted documentation that the patient continues to have acute HAE attacks"</li> <li>▪ Revised Item 4 from "The patient has had a decrease in the frequency of acute attacks or stabilization of disease from use of the requested agent" to read "The prescriber has communicated (via any means) with the patient regarding frequency and severity of attacks and has verified that the patient does not have &gt;1 month supply (sufficient for 2 acute attacks) currently on-hand"</li> </ul> <p><u>Initial Criteria Cinryze</u></p> <ul style="list-style-type: none"> <li>▪ Added Item 2 and 2 a "If the client has grandfathering, there is documentation that the patient is already being treated with the requested agent AND the following:       <ol style="list-style-type: none"> <li>a. If the agent is prescribed for acute HAE attacks, then the patient is receiving only ONE target agent indicated for treatment of acute HAE attacks"</li> </ol> </li> <li>▪ In Item 3 added "If the client does not have grandfathering or does have grandfathering but the patient is not currently on the medication" to read "If the client does not have grandfathering or does have grandfathering but the patient is not currently on the medication, ALL of the following:"</li> <li>▪ In Item 3 a added "evidenced by one of the following:" to read "The patient has a diagnosis of Type I or Type II hereditary angioedema (HAE) evidenced by one of the following:"</li> <li>▪ In Item 3 a i added "BOTH of the following (there must be", "low", "for each test" and removed "of TWO of the following labs", "or by the following specific lab value)" to read "BOTH of the following (there must be TWO separate low measurements for each test defined as below the testing laboratory's lower limit of the normal range):"</li> <li>▪ In Item 3 a i a) revised "C4 level less than 20 mg/dL (range 20-58 mg/dL)" to read "Low Serum complement factor 4 (C4) level"</li> <li>▪ In Item 3 a i b) revised "C1-INH functional level less than 68% (normal <math>\geq</math> 68%) OR C4 level less than 20 mg/dL (range 20-58 mg/dL)" to read "EITHER Low C1-INH antigenic level OR Low C1-INH functional"</li> <li>▪ Added 3 b ii "The patient has a mutation in the C1INH gene altering protein synthesis and/or function"</li> <li>▪ In Item 3 b i added "AND the following:" to read "The requested agent will be used to treat HAE acute attacks AND the following:"</li> <li>▪ Added Item 3 b i a) "The patient is receiving only ONE agent indicated for treatment of acute HAE attacks"</li> <li>▪ In Item 3 b ii removed "against HAE attacks" to read "The agent will be used for prophylaxis and BOTH of the following:"</li> <li>▪ Added Item 3 b ii b) "ONE of the following:"</li> <li>▪ In Item 3 b ii b) 1) added "and failed" to read "the patient has tried and failed danazol, aminocaproic acid, or tranexamic acid"</li> </ul>
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	<ul style="list-style-type: none"> <li>▪ In Item 5 a added "and within the quantity limit" to read "The dose is within the FDA labeled or clinically supported dose and within the quantity limit"</li> </ul> <p><u>Renewal Criteria Cinryze</u></p> <ul style="list-style-type: none"> <li>▪ Added Items 2, 2a, 2ai, 2aii, 2aiii, and 2b</li> </ul> <p>"2. ONE of the following:</p> <p>a. The requested agent was initially approved for acute HAE attacks and ALL of the following:</p> <ul style="list-style-type: none"> <li>i. The patient is receiving only ONE agent indicated for treatment of acute HAE attacks AND</li> <li>ii. The prescriber has submitted documentation that the patient continues to have acute HAE attacks AND</li> <li>iii. The prescriber has communicated (via any means) with the patient regarding frequency and severity of attacks and has verified that the patient does not have &gt;1 month supply (sufficient for 2 acute attacks) currently on-hand OR</li> </ul> <p>b. The requested agent was initially approved for prophylaxis of HAE attacks and the following:"</p> <ul style="list-style-type: none"> <li>▪ In Item 2 b i removed "or stabilization of disease from use of the requested agent" and added "from baseline (prior to treatment)" to read "The patient has had a decrease in the frequency of acute attacks from baseline (prior to treatment)"</li> <li>▪ In Item 4 a added "and within the quantity limit" to read "The dose is within the FDA labeled or clinically supported dose and within the quantity limit"</li> <li>▪ Updated the Contraindications chart</li> </ul>
	Rationale section updated
	References updated
04-01-2017	<p>In Description section:</p> <ul style="list-style-type: none"> <li>▪ Revised "FDA Labeled Indications and Dosage (Category A, B or C)" chart name to "FDA Approved Products for Acute Attacks and Routine Prophylaxis of Hereditary Angioedema (HAE)" and revised chart wording with no content intent changes.</li> </ul> <p>In Policy section:</p> <ul style="list-style-type: none"> <li>▪ For Berinert, Firazyr, Kalbitor or Ruconest and Cinryze sections, revised "Criteria" to "Evaluation" to read "Initial Evaluation"</li> </ul>
	Rationale section updated
	References updated

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