Pharmacy Medical Necessity Guidelines: Cinryze® (C1 Esterase Inhibitor [Human])

Effective: April 15, 2019

Prior Authorization Required ✓ Type of Review – Care Management ✓ Type of Review – Clinical Review
Not Covered

Pharmacy (RX) or Medical (MED) Benefit MED Department to Review PRECERT/MM

These pharmacy medical necessity guidelines apply to the following:

Commercial Products
- Tufts Health Plan Commercial products – large group plans
- Tufts Health Plan Commercial products – small group and individual plans
- Tufts Health Freedom Plan products – large group plans
- Tufts Health Freedom Plan products – small group plans
- CareLink℠ – Refer to CareLink Procedures, Services and Items Requiring Prior Authorization

Tufts Health Public Plans Products
- Tufts Health Direct – A Massachusetts Qualified Health Plan (QHP) (a commercial product)
- Tufts Health Together – MassHealth MCO Plan and Accountable Care Partnership Plans
- Tufts Health RITogether – A Rhode Island Medicaid Plan

Fax Numbers:
- All plans except Tufts Health Public Plans: PRECERT:617.972.9409
- Tufts Health Public Plans: MM: 888.415.9055

Note: This guideline does not apply to Medicare Members (includes dual eligible Members).

OVERVIEW

FOOD AND DRUG ADMINISTRATION-APPROVED INDICATIONS
Cinryze is a C1 esterase inhibitor indicated for routine prophylaxis against angioedema attacks in adults, adolescents, and pediatric patients (6 years of age and older) with Hereditary Angioedema (HAE).

Hereditary angioedema is a rare, episodic, autosomal dominant, swelling disorder that is characterized by C1 esterase inhibitor (C1-INH) deficiency. C1-INH coordinates the activation of the complement, contact, and fibrinolytic systems. A reduction in the activity of C1-INH may result in an elevated level of bradykinin, which is a key mediator in HAE symptoms. Patients with HAE may experience attacks of swelling and inflammation in the extremities, abdomen, face, urogenital tract, and/or the larynx that are random, recurrent, and potentially life-threatening. The age of onset is variable, ranging from early childhood to adult, with a worsening in frequency occurring around puberty. The age of onset can help to differentiate between HAE and acquired angioedema (AAE), which normally does not present until the fourth decade of life.

Treatment of HAE is divided into acute treatment, short-term/procedural prophylaxis to prevent an attack, and long-term/routine prophylaxis to minimize the frequency and severity of attacks. Long-term prophylaxis is recommended for patients who experience more than one attack per month, or for those who feel the condition is significantly impacting their lives. Short-term prophylaxis is recommended before dental procedures, minor surgery, endoscopy, or any situation where trauma may precipitate an attack; however, there are no FDA-approved agents currently available for procedural prophylaxis. A multifaceted approach that uses both pharmacologic and supportive therapies is required for optimal prevention and treatment of HAE.

COVERAGE GUIDELINES
The plan may authorize coverage of Cinryze (C1 inhibitor) for Members when all of the following criteria are met:
1. Documented diagnosis of hereditary angioedema by an immunologist or allergist
   AND
2. The Member’s history of HAE attacks is consistent with ≥1 of the following criteria:
   a) One or more abdominal or respiratory attacks per month
   b) History of laryngeal attacks
   c) Requires emergency medical care 3 or more times per year
   AND
3. Documentation the Member is NOT concurrently taking an angiotensin converting enzyme (ACE) inhibitor or estrogen replacement therapy
   AND
4. Documentation the Member has had an insufficient response or contraindication to both of the following classes of medication:
   a) 17α - alkylated androgens (e.g. danazol, stanozolol, oxandrolone, methyltestosterone)
   b) Antifibrinolytic agents (e.g. ε – aminocaproic acid, tranexamic acid)

**LIMITATIONS**
None

**CODES**
The following HCPCS/CPT code(s) are:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>J0598</td>
<td>Injection, C1 esterase inhibitor (human), 10 units</td>
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**REFERENCES**


**APPROVAL HISTORY**

March 10, 2009: Reviewed by Pharmacy & Therapeutics Committee.

Subsequent endorsement date(s) and changes made:
1. July 14, 2009: Removed criterion, “The Member has a history of at least two HAE attacks per month.” Removed criterion, “The Member has had an insufficient response or intolerance to corticosteroids and antihistamines.” Added “immunologist” to criteria #1. Added criteria #2, 3, and 4
2. January 1, 2010: Removal of Tufts Medicare Preferred language (separate criteria have been created specifically for Tufts Medicare Preferred)
3. February 16, 2010: Administrative Update: Removed temporary and miscellaneous billing codes and replaced with code J0598
5. July 12, 2011: No changes.
7. May 14, 2013: No changes.
8. April 8, 2014: No changes.
9. April 14, 2015: No changes.
10. January 1, 2016: Administrative change to rebranded template
11. March 8, 2016: No changes.
12. April 12, 2016: Effective 10/01/2016, Medical Necessity Guideline applies to Tufts Health Together.
15. August 7, 2018: No changes.
16. February 12, 2019: No changes.
17. April 9, 2019: Added allergist as a provider specialty to the Medical Necessity Guideline.

**BACKGROUND, PRODUCT AND DISCLAIMER INFORMATION**

Pharmacy Medical Necessity Guidelines have been developed for determining coverage for plan benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. The plan makes coverage decisions on a case-by-case basis considering the individual member's health care needs. Pharmacy Medical Necessity Guidelines are developed for selected therapeutic classes or drugs found to be safe, but proven to be effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in the service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. The plan revises and updates Pharmacy Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Pharmacy Medical Necessity Guideline and a self-insured Member's benefit document, the provisions of the benefit document will govern.

Treating providers are solely responsible for the medical advice and treatment of members. The use of this policy is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization and utilization management guidelines when applicable, and adherence to plan policies and procedures and claims editing logic.