TUFTS Health Plan

Pharmacy Medical Necessity Guidelines: Hereditary Angioedema Medications

Effective: August 1, 2023

Prior Authorization Required	√	Type of Review – Care Management	
Not Covered		Type of Review – Clinical Review	√
Pharmacy (RX) or Medical (MED) Benefit	RX	Department to Review	RXUM
These pharmacy medical necessity guidelines apply to the following: ☒ Tufts Health RITogether – A Rhode Island Medicaid Plan		**Fax Numbers:** RXUM: 617.673.0988	

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

OVERVIEW

FOOD AND DRUG ADMINISTRATION-APPROVED INDICATIONS

Haegarda (C1 Esterase Inhibitor [Human]) is a plasma-derived concentrate of C1 Esterase Inhibitor (Human) indicated for routine prophylaxis to prevent hereditary angioedema (HAE) attacks in patients 6 years of age and older.

Icatibant and Sajazir (icatibant) is a bradykinin B2 receptor antagonist indicated for the treatment of acute attacks of hereditary angioedema (HAE) in adults 18 years of age and older.

Orladeyo (berotralstat) is a plasma kallikrein inhibitor indicated for prophylaxis to prevent attacks of hereditary angioedema (HAE) in adults and pediatric patients 12 years and older.

Takhzyro (lanadelumab-flyo) is a plasma kallikrein inhibitor (monoclonal antibody) indicated for prophylaxis to prevent attacks of hereditary angioedema (HAE) in adult and pediatric patients 2 years and older.

COVERAGE GUIDELINES

Haegarda (C1 Esterase Inhibitor [Human])

The plan may authorization coverage of Haegarda for Members when all of the following criteria are met:

Initial Therapy

1. Documented diagnosis of hereditary angioedema

AND

2. Patient is at least 6 years of age

AND

3. Prescribed by or in consultation with an allergist, hematologist, or immunologist

AND

4. Documentation that "on-demand" therapy (e.g., icatibant, Kalbitor, Ruconest, Berinert) did not provide satisfactory control or access to "on-demand" therapy is limited

Reauthorization Criteria

1. Documented diagnosis of hereditary angioedema

AND

2. Patient is at least 6 years of age

AND

3. Prescribed by or in consultation with an allergist, hematologist, or immunologist

AND

4. Documentation of a positive clinical response as evidenced by **one (1)** of the following:
    a. An improvement in severity and duration of attacks has been achieved and sustained
    b. A decrease in attack frequency

Icatibant, Sajazir (icatibant)
The plan may authorization coverage of icatibant or Sajazir for Members when all of the following criteria are met:

1. Documented diagnosis of hereditary angioedema
AND
2. Patient is at least 18 years of age
AND
3. Prescribed by or in consultation with an allergist, hematologist, or immunologist
AND
4. Documentation the patient has a history of at least one (1) severe attack within the past 6 months

Orladeyo (berotralstat)
The plan may authorization coverage of Orladeyo for Members when all of the following criteria are met:
Initial Therapy

1. Documented diagnosis of hereditary angioedema
AND
2. Patient is at least 12 years of age
AND
3. Prescribed by or in consultation with an allergist, hematologist, or immunologist
AND
4. Documentation that "on-demand" therapy (e.g., icatibant, Kalbitor, Ruconest, Berinert) did not provide satisfactory control or access to "on-demand" therapy is limited

Reauthorization Criteria

1. Documented diagnosis of hereditary angioedema
AND
2. Patient is at least 12 years of age
AND
3. Prescribed by or in consultation with an allergist, hematologist, or immunologist
AND
4. Documentation of a positive clinical response as evidenced by **one (1)** of the following:
    a. An improvement in severity and duration of attacks has been achieved and sustained
    b. A decrease in attack frequency

Takhzyro (lanadelumab-flyo)
The plan may authorization coverage of Takhzyro for Members when all of the following criteria are met:
Initial Therapy

1. Documented diagnosis of hereditary angioedema
AND
2. Patient is at least 2 years of age
AND
3. Prescribed by or in consultation with an allergist, hematologist, or immunologist
AND
4. Documentation that "on-demand" therapy (e.g., icatibant, Kalbitor, Ruconest, Berinert) did not provide satisfactory control or access to "on-demand" therapy is limited

Reauthorization Criteria

1. Documented diagnosis of hereditary angioedema
AND
2. Patient is at least 2 years of age
AND
3. Prescribed by or in consultation with an allergist, hematologist, or immunologist
AND
4. Documentation of a positive clinical response as evidenced by **one (1)** of the following:
    a. An improvement in severity and duration of attacks has been achieved and sustained
    b. A decrease in attack frequency
AND
5. For patients who have been attack free for 12 months, provider attestation that consideration has been given to changing the patient to a dosing interval of 300 mg every four (4) weeks

LIMITATIONS

- Haegarda and Orladeyo will be authorized for 12 months.
- Takhyzro will be authorized for 6 months.
- Patients new to the plan stable on Haegarda, Orladyo, or Takhyzro should be reviewed against Initial Therapy.
- The plan does not cover brand Firazyr. Refer to the Pharmacy Medical Necessity Guideline for Non-Formulary Exceptions.

CODES

None

REFERENCES

1. Aberer W, Maurer M, Reshef A, et al. Open-label, multicenter study of self-administered icatibant for attacks of hereditary angioedema. Allergy. 2014 Mar;69(3):305-14.
2. Banerji A, Riedl M, Bernstein J et al. Lanadelumab for prevention of attacks in hereditary angioedema: results from the phase 3 HELP study. Ann Allergy Asthma Immunol. 2017; 119(5): S5. Abstract OR034.
3. Bowen T, Cicardi M, Farkas H, et al. 2010 International consensus algorithm for the diagnosis, therapy, and management of hereditary angioedema. Allergy Asthma Clin Immunol. 2010;6(1):24.
4. Cicardi M, Bork K, Caballero T, et al. Evidence-based recommendations for the therapeutic management of angioedema owing to hereditary C1 inhibitor deficiency: consensus report of an International Working Group. Allergy. 2012; 67:147-57.
5. Craig T, Riedl M, Dykewicz MS et al. When is prophylaxis for hereditary angioedema necessary? Ann Allergy Asthma Immunol. 2009; 102:366-72.
6. Epstein TG, Bernstein JA. Current and emerging management options for hereditary angioedema in the US. Drugs. 2008; 68(18):2561-73.
7. Firazyr (icatibant) [prescribing information]. Lexington, MA: Shire Orphan Therapies, Inc.; October 2021.
8. Frank, MM. Hereditary angioedema: the clinical syndrome and its management in the United States. Immunol Allergy Clin North Am. 2006; 26(4):653-68.
9. Frank, MM. Hereditary angioedema. J Allergy Clin Immunol. 2008; 121(2 Suppl):S398-401.
10. Haegarda (C1 Esterase Inhibitor [Human]) [package insert]. Marburg, Germany: CSL Behring GmbH., January 2022.
11. Lin G, Agboola F, Chapman R et al. Prophylaxis for hereditary angioedema with lanadelumab and C1 inhibitors: effectiveness and value. Draft evidence report. 2018 August 23. URL: https://icerreview.org/wp-content/uploads/2018/03/ICER_HAE_Draft_Evidence_Report_082318.pdf. Available from Internet. Accessed 2018 August 31.
12. Lumry WR, Li HH, Levy RJ et al. Results from FAST-3: a phase III randomized, double-blind, placebo-controlled, multicenter study of subcutaneous icatibant in patients with acute hereditary angioedema (HAE) attacks. J Allergy Clin Immunol. 2011; 127(2):AB1. Abstract 2.
13. Lumry WR, Li HH, Levy RJ et al. Randomized placebo-controlled trial of the bradykinin B_2 receptor antagonist icatibant for the treatment of acute attacks of hereditary angioedema: the FAST-3 trial. Ann Allergy Asthma Immunol. 2011 Dec;107(6):529-37.
14. Maurer M, Magerl M, Ansotegui I, et al. The international WAO/EAACI guideline for the management of hereditary angioedema – the 2017 revision and update. World Allergy Organization Journal. 2018;11(5):1-20.
15. Orladeyo (berotralstat) [prescribing information]. Durham, NC: BioCryst Pharmaceuticals, Inc.; December 2020.
16. Sachse MM, Khachemoune A, Guldbakke KK et al. Hereditary angioedema. J Drugs Dermatol. 2006; 5(9):848-52.
17. Takhzyro (lanadelumab-flyo) [prescribing information]. Lexington, MA: Dyax Corp.; 2023 Feb.
18. Weis M. Clinical review of hereditary angioedema: diagnosis and management. Postgrad Med J 2009; 121(6):113-20.
19. Zuraw BL, Banerji A, Bernstein JA et al. US Hereditary Angioedema Association Medical Advisory Board 2013 recommendations for the management of hereditary angioedema due to C1 inhibitor deficiency. J Allergy Clin Immunol Pract. 2013a; 1(5):458-67.
20. Zuraw B, Bernstein J, Lang D et al. A focused parameter update: hereditary angioedema, acquired C1 inhibitor deficiency, and angiotensin-converting enzyme inhibitor-associated angioedema. J Allergy Clin Immunol. 2013b; 131(6): 1491-3.

APPROVAL HISTORY

September 13, 2022: Reviewed by Pharmacy & Therapeutics Committee.

- May 9, 2023: Updated approval duration and age requirements for Takhzyro (effective August 1, 2023).

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. Provider Services