Berinert (C1 esterase inhibitor [human])

<table>
<thead>
<tr>
<th>Line(s) of Business:</th>
<th>Original Effective Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>HMO; PPO; QUEST Integration</td>
<td>10/01/2015</td>
</tr>
<tr>
<td>Medicare Advantage</td>
<td>Current Effective Date:</td>
</tr>
<tr>
<td></td>
<td>12/1/2017</td>
</tr>
<tr>
<td></td>
<td>05/01/2019</td>
</tr>
</tbody>
</table>

POLICY
A. INDICATIONS
The indications below including FDA-approved indications and compendial uses are considered a covered benefit provided that all the approval criteria are met and the member has no exclusions to the prescribed therapy.

FDA-Approved Indication
Treatment of acute abdominal, facial, or laryngeal attacks of hereditary angioedema (HAE) in adult and pediatric patients
Treatment of acute abdominal, facial, or laryngeal hereditary angioedema (HAE) attacks in adult and pediatric patients

B. REQUIRED DOCUMENTATION
The following information is necessary to initiate the prior authorization review:
- Initial therapy
  - Laboratory report with C4 level, C1 inhibitor antigenic protein level and/or C1 inhibitor functional activity
  - For the diagnosis of HAE with normal C1 inhibitor, F12 gene mutation testing results (if applicable)
- Continuation of therapy
  - Documentation supporting a positive clinical response to therapy with Berinert (e.g., chart notes, medical records)

C. CRITERIA FOR APPROVAL
Authorization of 12 months may be granted for treatment of hereditary angioedema attacks when either of the following criteria is met:
1. Member has C1 inhibitor deficiency or dysfunction as confirmed by laboratory testing.
2. Member has normal C1 inhibitor as confirmed by laboratory testing and meets one of the following criteria:
   a. Member has an F12, angiopoietin-1, or plasminogen gene mutation as confirmed by genetic testing, or
   b. Member has a family history of angioedema and the angioedema was refractory to a trial of high-dose antihistamine (e.g., cetirizine) for at least one month.

Hereditary Angioedema
Authorization of 12 months may be granted to members who meet ALL of the following criteria:
1. Berinert is being requested for the treatment of acute HAE attacks
2. Diagnostic laboratory testing for HAE has been performed including C4 level, C1 inhibitor antigenic protein level and/or C1 inhibitor functional activity.

3. For members with HAE with C1 inhibitor deficiency (HAE type I or type II):
   a. Low C4 level, and
   b. Low C1 inhibitor antigenic protein level and/or low C1 inhibitor functional activity (below the lower limit of normal as defined by the laboratory performing the test).

4. For members with HAE with normal C1 inhibitor (HAE type III):
   a. Normal C4 level, normal C1 inhibitor antigenic protein level and normal C1 inhibitor functional activity.
   b. Member meets EITHER of the following criteria:
      i. Member tested positive for the F12 gene mutation
      ii. Member has a family history of angioedema
   c. Other causes of angioedema have been ruled out (e.g., drug-induced).

D. CONTINUATION OF THERAPY

   Authorization of 12 months may be granted for continuation of therapy when all of the following criteria are met:

   1. Member meets the criteria for initial approval.
   2. Member has experienced reduction in severity and duration of attacks since starting treatment.

   No previous authorization/precertification:

   All members (including new members and members currently receiving treatment without prior authorization) must meet criteria for initial approval in section C.

   Reauthorization:

   Hereditary Angioedema:

   Authorization of 12 months may be granted to members requesting authorization for continuation of therapy if Berinert was previously authorized by HMSA/CVS and member demonstrated a clinical response to therapy.

E. DOSAGE AND ADMINISTRATION

   Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

F. ADMINISTRATIVE GUIDELINES

   Precertification is required. Please refer to the HMSA medical policy web site for the fax form.

G. IMPORTANT REMINDER

   The purpose of this Medical Policy is to provide a guide to coverage. This Medical Policy is not intended to dictate to providers how to practice medicine. Nothing in this Medical Policy is intended to discourage or prohibit providing other medical advice or treatment deemed appropriate by the treating physician.

   Benefit determinations are subject to applicable member contract language. To the extent there are any conflicts between these guidelines and the contract language, the contract language will control.

   This Medical Policy has been developed through consideration of the medical necessity criteria under Hawai’i’s Patients’ Bill of Rights and Responsibilities Act (Hawaii Revised Statutes §432E-1.4), generally accepted standards of medical practice and review of medical literature and government
approval status. HMSA has determined that services not covered under this Medical Policy will not be medically necessary under Hawaii law in most cases. If a treating physician disagrees with HMSA/CVS’s determination as to medical necessity in a given case, the physician may request that CVS/caremark/HMSA reconsider the application of the medical necessity criteria to the case at issue in light of any supporting documentation.

H. REFERENCES


Document History

<table>
<thead>
<tr>
<th>Date</th>
<th>Event Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>10/01/2015</td>
<td>Original effective date</td>
</tr>
<tr>
<td>08/2016</td>
<td>Annual review</td>
</tr>
<tr>
<td>12/01/2017</td>
<td>Revision effective date</td>
</tr>
<tr>
<td>10/2018</td>
<td>Annual review — adopt Enhanced SGM-hybrid</td>
</tr>
<tr>
<td>05/01/2019</td>
<td>Revision effective date</td>
</tr>
</tbody>
</table>