

Clinical Policy: C1 Esterase Inhibitors (Berinert, Cinryze, Haegarda, Ruconest)

Reference Number: CP.PHAR.202

Effective Date: 03.01.16

Last Review Date: 02.20

Line of Business: Commercial, HIM*, Medicaid

[Coding Implications](#)

[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

Description

The following are C1 esterase inhibitors requiring prior authorization: human C1 esterase inhibitor (Berinert[®], Cinryze[®], Haegarda[®]) and recombinant C1 esterase inhibitor (Ruconest[®]).

**For Health Insurance Marketplace (HIM), if request is through pharmacy benefit, Berinert is non-formulary and should not be approved using these criteria; refer to the formulary exception policy, HIM.PA.103.*

FDA Approved Indication(s)

C1 esterase inhibitors are indicated:

- For the treatment of acute attacks of hereditary angioedema (HAE) in adolescent and adult patients [*Berinert and Ruconest only*]
- For the routine prophylaxis against angioedema attacks in adolescent and adult patients with HAE [*Cinryze and Haegarda only*]

Limitation(s) of use:

- The safety and efficacy of Berinert for prophylactic therapy have not been established.
- Effectiveness of Ruconest was not established in HAE patients with laryngeal attacks.

Policy/Criteria

Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of health plans affiliated with Centene Corporation[®] that Berinert, Cinryze, Haegarda, and Ruconest are **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Hereditary Angioedema (must meet all):

1. Diagnosis of HAE confirmed by one of the following (a or b):
 - a. Low C4 level and low C1-INH antigenic or functional level (*see Appendix D*);
 - b. Normal C4 level and normal C1-INH levels, and both of the following (i and ii):
 - i. History of recurrent angioedema;
 - ii. Family history of angioedema;
2. Prescribed by or in consultation with a/an hematologist, allergist, or immunologist;
3. Member meets one of the following (a, b, c, or d):
 - a. Age \geq 5 years for Berinert;
 - b. Age \geq 6 years for Cinryze;

- c. Age \geq 12 years for Haegarda;
- d. Age \geq 13 years for Ruconest;
- 4. Member meets one of the following (a, b, or c):
 - a. For treatment of acute HAE attacks, meets one of the following (i or ii):
 - i. Request is for Berinert;
 - ii. Request is for Ruconest and member does not experience laryngeal attacks;
 - b. For long-term prophylaxis of HAE attacks, meets all of the following (i and ii):
 - i. Request is for Cinryze or Haegarda;
 - ii. 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;
 - c. For short-term prophylaxis of HAE attacks, member requires major dental work or surgical procedure;
- 5. Member is not using the requested product in combination with another FDA-approved product for the same indication (e.g., using both Berinert and Firazyr® for acute HAE attacks);
- 6. Dose does not exceed:
 - a. Berinert: 20 IU/kg of body weight per single dose, up to 2 doses administered in a 24-hour period;
 - b. Cinryze: 2,500 units (5 vials) every 3 to 4 days;
 - c. Haegarda: 60 IU/kg of body weight per dose twice weekly;
 - d. Ruconest: 4,200 IU per single dose, up to 2 doses administered in a 24-hour period.

Approval duration:

Short-term prophylaxis: 2 doses per procedure

Treatment of acute attacks: Up to 4 doses per month

Medicaid/HIM – 6 months

Commercial – 6 months or to the member’s renewal date, whichever is longer

Long-term prophylaxis:

Medicaid/HIM – 6 months

Commercial – 6 months or to the member’s renewal date, whichever is longer

B. Other diagnoses/indications

- 1. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.CPA.09 for commercial, HIM.PHAR.21 for health insurance marketplace, and CP.PMN.53 for Medicaid.

II. Continued Therapy

A. Short Term Prophylaxis of Hereditary Angioedema Attacks

- 1. Re-authorization is not permitted. Members must meet the initial approval criteria.

Approval duration: Not applicable

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

- 1. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;

2. Member is responding positively to therapy (e.g., if Cinryze or 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 in combination with another FDA-approved product for the same indication (e.g., both Berinert and Firazyr for acute HAE attacks);
4. If request is for a dose increase, new dose does not exceed:
 - a. Berinert: 20 IU/kg of body weight per single dose, up to 2 doses administered in a 24-hour period;
 - b. Cinryze: 2,500 units (5 vials) every 3 to 4 days;
 - c. Haegarda: 60 IU/kg of body weight per dose twice weekly;
 - d. Ruconest: 4,200 IU per single dose, up to 2 doses administered in a 24-hour period.

Approval duration:

Treatment of acute attacks: Up to 4 doses per month

Medicaid/HIM – 12 months

Commercial – 6 months or to the member’s renewal date, whichever is longer

Long-term prophylaxis:

Medicaid/HIM – 12 months

Commercial – 6 months or to the member’s renewal date, whichever is longer

C. Other diagnoses/indications (must meet 1 or 2):

1. Currently receiving medication via Centene benefit and documentation supports positive response to therapy.

Approval duration: Duration of request or 6 months (whichever is less); or

2. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.CPA.09 for commercial, HIM.PHAR.21 for health insurance marketplace, and CP.PMN.53 for Medicaid.

III. Diagnoses/Indications for which coverage is NOT authorized:

- A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policies – CP.CPA.09 for commercial, HIM.PHAR.21 for health insurance marketplace, and CP.PMN.53 for Medicaid or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

C1-INH: C1 esterase inhibitor

C4: complement component 4

FDA: Food and Drug Administration

HAE: hereditary angioedema

Appendix B: Therapeutic Alternatives

Not applicable

Appendix C: Contraindications/Boxed Warnings

- Contraindication(s):

- Ruconest: known or suspected allergy to rabbits and rabbit derived products
- Ruconest, Berinert, Cinryze, Haegarda: history of immediate/life-threatening hypersensitivity reactions, including anaphylaxis, to C1 esterase inhibitor preparations
- Boxed warning(s): none reported

Appendix D: General Information

- Diagnosis of HAE:
 - There are two classifications of HAE: HAE with C1-INH deficiency (further broken down into Type 1 and Type II) and HAE of unknown origin (also known as Type III).
 - In both Type 1 (~85% of cases) and Type II (~15% of cases), C4 levels are low. C1-INH antigenic levels are low in Type I while C1-INH functional levels are low in Type II. Diagnosis of Type I and II can be confirmed with laboratory tests. Reference ranges for C4 and C1-INH levels can vary across laboratories (see below for examples); low values confirming diagnosis are those which are below the lower end of normal.

Laboratory Test & Reference Range	Mayo Clinic	Quest Diagnostics	LabCorp
C4	14-40 mg/dL	16-47 mg/dL	13-44 mg/dL
C1-INH, antigenic	19-37 mg/dL	21-39 mg/dL	21-39 mg/dL
C1-INH, functional	Normal: > 67% Equivocal: 41-67% Abnormal: < 41%	Normal: ≥ 68% Equivocal: 41-67% Abnormal: ≤ 40%	Normal: > 67% Equivocal: 41-67% Abnormal: < 41%

- Type III, on the other hand, presents with normal C4 and C1-INH levels. Some patients have an associated mutation in the FXII gene, while others have no identified genetic indicators. Type III is very rare (number of cases unknown), and there are no laboratory tests to confirm the diagnosis. Instead, the diagnosis is clinical and supported by recurrent episodes of angioedema with a strong family history of angioedema.
- HAE attack triggers may include minor trauma (such as dental procedures), oral contraceptives, and ACE inhibitors.
- Bowen T, Cicardi M, Farkas H, et al. recommend plasma-derived C1 inhibitors for short-term prophylaxis: 10 to 20 units per kg one dose 1 hour before surgery or less than 6 hours before procedures (must be given before endotracheal intubation/manipulations) with a second dose of equal amount available during surgery.

V. Dosage and Administration

Drug Name	Indication	Dosing Regimen	Maximum Dose
human C1 esterase inhibitor (Berinert)	Treatment of acute HAE attacks	20 IU/kg body weight IV	Based on weight
human C1 esterase inhibitor (Haegarda)	Prophylaxis against HAE attacks	60 IU/kg body weight SC twice weekly (every 3 or 4 days)	Based on weight

Drug Name	Indication	Dosing Regimen	Maximum Dose
human C1 esterase inhibitor (Cinryze)	Prophylaxis against HAE attacks	Age 6-11yo: 500 units IV every 3-4 days Age ≥ 12yo: 1,000 units IV every 3-4 days	2,500 units (not exceeding 100 units/kg) every 3-4 days
recombinant C1 esterase inhibitor (Ruconest)	Treatment of acute HAE attacks	Weight < 84 kg: 50 units/kg IV Weight ≥ 84 kg: 4,200 units IV May administer a second dose if symptoms persist.	4,200 units/dose; up to 2 doses within a 24-hour period

VI. Product Availability

Drug Name	Availability
human C1 esterase inhibitor (Berinert)	Vial with powder for reconstitution: 500 IU
human C1 esterase inhibitor (Haegarda)	Vial with powder for reconstitution: 2,000 IU, 3000 IU
human C1 esterase inhibitor (Cinryze)	Vial with powder for reconstitution: 500 units
recombinant C1 esterase inhibitor (Ruconest)	Vial with powder for reconstitution: 2,100 units

VII. References

1. Berinert Prescribing Information. Marburg, Germany: CSL Behring GmbH; April 2019. Available at: www.berinert.com. Accessed November 4, 2019.
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3. Ruconest Prescribing Information. Raleigh, NC: Santarus Inc.; March 2018. Available at: www.ruconest.com. Accessed November 4, 2019.
4. Haegarda Prescribing Information. Kankakee, IL: CSL Behring LLC; October 2017. Available at: www.haegarda.com. Accessed November 4, 2019.
5. 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
6. 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(2): 147-157.
7. Cicardi M, Aberer W, Banerji A, et al. Classification, diagnosis, and approach to treatment for angioedema: consensus report from the Hereditary Angioedema International Working Group. *Allergy*. 2014; 69(5): 602-616.

8. Craig T, Pursun E, Bork K, et al. WAO guideline for the management of hereditary angioedema. WAO Journal. 2012; 5: 182-199.
9. 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.
10. 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.
11. Maurer M, Magerl M, Ansotegui I, et al. The international WAO/EAACI guideline for the management of hereditary angioedema – the 2017 revision and update. Allergy. 2018; 73(8):1575-1596.
12. Mayo Clinic Laboratories [internet database]. Rochester, Minnesota: Mayo Foundation for Medical Education and Research. Updated periodically. Accessed November 4, 2019.
13. Quest Diagnostics ® [internet database]. Updated periodically. Accessed November 4, 2019.
14. LabCorp [internet database]. Burlington, North Carolina: Laboratory Corporation of America. Updated periodically. Accessed November 4, 2019.

Coding Implications

Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

HCPCS Codes	Description
C9015	Injection, C-1 esterase inhibitor (human), Haegarda, 10 units
J0597	Injection, C-1 esterase inhibitor (human), Berinert, 10 units
J0598	Injection, C-1 esterase inhibitor (human), Cinryze, 10 units
J0596	Injection, C-1 esterase inhibitor (recombinant), Ruconest, 10 units

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Medicaid: Policy converted to new template and split from CP.PHAR.46.HAE Treatment. Criteria: added dosing/max dose criteria per PIs; increased approval from one dose to up to two doses in 24 hours for Berinert.	02.16	03.16
Medicaid: Age changed from ≥ 13 to ≥ 12 , per the FDA definition of adolescent.	05.16	
Medicaid: Added criteria to confirm diagnosis. Removed age requirement. Increased approval duration to 12 months for Berinert/Ruconest and incorporated recommended dosing from PI. Added criteria for continued approval. Removed warnings against hypersensitivity reactions. For Cinryze, modified initial approval duration for long-term prophylaxis to 6 months and for renewal to 12 months. For	02.17	03.17

Reviews, Revisions, and Approvals	Date	P&T Approval Date
continued therapy, added max dose criteria and reasons to discontinue.		
1Q18 annual review: policies combined for commercial and Medicaid; Added Haegarda into the policy; Medicaid: added specialist requirement, removed “Other types of angioedema have been ruled out” from part of diagnosis due to its subjective nature, while specialist has been added; removed qualifying descriptions of “abdominal, facial, or laryngeal attacks” for Berinert as there is no evidence that there is lack of efficacy in other forms of HAE; added short-term prophylaxis for plasma-derived C1 esterase inhibitors according to AOW treatment guidelines; references reviewed and updated.	11.15.17	02.18
1Q19 annual review: added age requirements for all C1 esterase inhibitors; removed trial of danazol for long-term prophylaxis per WHO/EAACI 2017 guidelines; added requirement that member is not using requested product in combination with other approved treatments for the same indication; added quantity limit of 4 doses per month for treatment of acute attacks; revised approval duration for acute attacks and long-term prophylaxis to 6 months or member’s renewal date for Commercial; added requirement that members requesting continued therapy for short term prophylaxis must meet initial criteria; references reviewed and updated.	11.06.18	02.19
Added HIM line of business due to addition of agent(s) to the HIM formulary with PA	03.14.19	
1Q20 annual review: initial auth duration for Medicaid & HIM LOBs revised to 6 months for alignment; removed specific C1 esterase inhibitor options for short-term prophylaxis; HAE lab reference range updated; references reviewed and updated.	11.27.19	02.20

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

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Note:

For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

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