curative

Hereditary Angioedema (HAE) Prior Authorization

Drug(s) Applied:	**icatibant, Haegarda** (C1 Esterase Inhibitor (Human))

Criteria:
Drug(s) Applied will be approved when the requested medication is being used for an FDA approved indication and all of the following criteria are met:

I. Initial Therapy Criteria
- **A. Hereditary angioedema, acute treatment** as indicated by chart notes within past 120 days
  1. Requested drug is icatibant and will be used to treat acute HAE attacks **and**
  2. ONE of the following:
     - a) Diagnosis of C1INH deficiency or dysfunction [HAE-C1INH (Type 1 or Type 2)] confirmed by BOTH of the following:
       - (1) C1-INH antigenic or functional level below the lower limit of normal **and**
       - (2) Serum C4 level below the lower limit of normal **or**
     - b) Diagnosis of normal C1INH (HAE-nl-C1INH) confirmed with levels within the normal range for C1-INH protein level, C1-INH function level, and C4 level as identified by prescriber **and**
       - (1) ONE of the following:
         - (a) Diagnosis is associated with a mutation in ONE of the following genes:
           - (i) Coagulation factor FXII (mutation in F12)
           - (ii) Plasminogen
           - (iii) Angiopoietin-1
           - (iv) Kininogen1
           - (v) Heparan sulfate 3-O-sulfotransferase 6 gene
           - (vi) Myoferlin gene **or**
         - (b) Diagnosis of HAE-unknown mutation (HAE-U) that has been confirmed by an HAE specialist (medical records required) with family history of angioedema **and**
           - **(i)** Angioedema is refractory to high-dose antihistamine trial of at least one month **and**
  3. Chart notes do not indicate evidence of other causes of angioedema with documentation reflecting that other causes of angioedema have been ruled out

(ex: angioedema due to ACE-Inhibitors, estrogens, angiotensin II receptor blockers, etc) **and**

4. Prescriber is a specialist or has consulted with a specialist in the area of the patient's diagnosis (e.g., allergy and immunology, HAE specialist) **and**
5. Chart notes and/or prescriber do not provide documentation of concurrent use of other agents used to treat acute HAE (i.e., Berinert, Firazyr,, Kalbitor, Ruconest, Sajazir, Ekterly)

Approval Duration: 6 months

B. Hereditary angioedema due to C1INH deficiency [HAE-C1INH (Type 1 or Type 2)], prophylaxis as indicated by chart notes within past 90 days

1. Requested drug is Haegarda and will be used for long-term prophylaxis **and**
2. Diagnosis confirmed by:
    a) C1-INH antigenic or functional level below the lower limit of normal **and**
    b) Serum C4 level below the lower limit of normal **and**
3. Patient has evidence of clinically significant HAE, demonstrated by at least ONE of the following:
    a) At least three (3) clinically documented moderate to severe HAE attacks per month requiring treatment with an on-demand HAE medication. Qualifying attacks should be consistent with HAE manifestations (ie cutaneous swelling, laryngeal edema, or recurrent episodic abdominal attacks). For attacks presenting primarily as abdominal pain, documentation should support that symptoms are attributable to HAE (ie, associated HAE features or clinician assessment), **or**
    b) A history of laryngeal or upper airway HAE attack(s), **or**
    c) A history of HAE attacks resulting in hospitalization, emergency department visit, or significant functional impairment despite access to appropriate on-demand therapy, **and**
4. Chart notes do not indicate evidence of other causes of angioedema with documentation reflecting that other causes of angioedema have been ruled out (ex: angioedema due to ACE-Inhibitors, estrogens, angiotensin II receptor blockers, etc) **and**
5. Prescriber is a specialist or has consulted with a specialist in the area of the patient's diagnosis (e.g., allergy and immunology, HAE specialist) **and**
6. Chart notes and/or prescriber do not provide documentation of concurrent use of other agents used for prophylaxis of HAE attacks (i.e., Cinryze, Takhzyro, Orladeyo, Andembry, Dawnzera) **and**
7. Patient's weight is provided to validate that the requested dosing is within the parameters, described below.

Approval Duration: 6 months
Dosing: Maximum dose of 60 IU/kg per injection no more frequently than twice weekly with doses separated by at least 3 days.

II. Continued Therapy Criteria

A. Hereditary angioedema, acute treatment as indicated by chart notes within past 12 months

1. Requested drug is icatibant **and**
2. Patient has been previously approved for the requested agent through the plan's Prior Authorization process or meets the initial therapy criteria above **and**
3. Documented clinical benefit since starting the requested agent (i.e., decrease in duration of HAE attacks, quick onset of symptom relief, complete resolution of symptoms, or decrease in attack frequency/severity) **and**
4. Chart notes and/or prescriber do not provide documentation of concurrent use of other agents indicated for the treatment of acute HAE attacks (i.e., Berinert, Firazyr, Kalbitor, Ruconest, Sajazir, Ekterly) **and**
5. Prescriber is a specialist or has consulted with a specialist in the area of the patient's diagnosis (e.g., allergy and immunology, HAE specialist)

Approval Duration: 12 months

B. Hereditary angioedema, prophylaxis as indicated by chart notes within past 12 months

1. Requested drug is Haegarda **and**
2. Diagnosis confirmed by ONE of the following:
    a) C1-INH antigenic or functional level below the lower limit of normal **and**
    b) serum C4 level below the lower limit of normal **and**
3. Documented clinical benefit since starting the requested agent by at least ONE of the following:
    a) A decrease in the frequency of HAE attacks from baseline (prior to treatment) **or**
    b) A decrease in HAE attack severity **or**
    c) A decrease in duration of HAE attacks **and**
4. Chart notes do not indicate evidence of other causes of angioedema with documentation reflecting that other causes of angioedema have been ruled out (ex: angioedema due to ACE-Inhibitors, estrogens, angiotensin II receptor blockers, etc) **and**
5. Chart notes and/or prescriber do not provide documentation of concurrent use of other agents indicated for prophylaxis of HAE attacks (i.e., Cinryze, Takhzyro, Orladeyo, Andembry, Dawnzera) **and**

6. Prescriber is a specialist or has consulted with a specialist in the area of the patient's diagnosis (e.g., allergy and immunology, HAE specialist) **and**
7. Patient's weight is provided to validate that the requested dosing is within the parameters, described below.

Approval Duration: 12 months

Dosing: Maximum dose of 60 IU/kg per injection no more frequently than twice weekly with doses separated by at least 3 days.

References:

1. US HAEA Medical Advisory Board 2020 Guidelines for the Management of Hereditary Angioedema. Busse PJ, Christiansen SC, Riedl MA, et al. J Allergy Clin Immunol Pract. 2021.
2. 2025 WAO Guidelines for the Classification, Diagnosis, and Treatment of Hereditary Angioedema. World Allergy Organization Journal. 2026.
3. Hereditary Angioedema with Normal C1 Inhibitor: an Updated International Consensus Paper on Diagnosis, Pathophysiology, and Treatment. Allergy and Immunology. 2025.
4. The International/Canadian Hereditary Angioedema Guideline. Allergy, Asthma & Clinical Immunology. 2019.
5. A Focused Parameter Update: Hereditary Angioedema, Acquired C1 Inhibitor Deficiency, and Angiotensin-Converting Enzyme Inhibitor–Associated Angioedema. Zuraw BL, Bernstein JA, Lang DM, et al. AAAAI. J Allergy Clin Immunol. 2013.
6. https://www.haea.org/assets/img/TreatmentGuidelines040321.pdf
7. Icatibant prescribing information. Teva Pharmaceuticals USA, Inc. February 2024.
8. Haegarda prescribing information. CSL Behring. January 2022.

Policy Owned by: Curative PBM team