POLICY Document for CINRYZE (C1 esterase inhibitor [human])

The overall objective of this policy is to support the appropriate and cost-effective use of the medication, specific to use of preferred medication options, lower cost site of care and overall, clinically appropriate use. This document provides specific information to each of the three sections of the overall policy.

Section 1: Site of Care

- Policy information specific to site of care (outpatient, hospital outpatient, home infusion)

Section 2: Clinical Criteria

- Policy information specific to the clinical appropriateness for the medication

Section 1: Site of Care

Site of Care Criteria
Administration of Intravenous Cinryze

POLICY

I. CRITERIA FOR APPROVAL FOR ADMINISTRATION IN OUTPATIENT HOSPITAL SETTING

This policy provides coverage for administration of Cinryze in an outpatient hospital setting for up to 45 days when a member is new to therapy or is reinitiating therapy after not being on therapy for at least 6 months.

This policy provides coverage for administration of Cinryze in an outpatient hospital setting for a longer course of treatment when ANY of the following criteria are met:

A. The member has experienced an adverse reaction to the drug that did not respond to conventional interventions (eg, acetaminophen, steroids, diphenhydramine, fluids or other pre-medications) or a severe adverse event (anaphylaxis, anaphylactoid reactions, myocardial infarction, thromboembolism, or seizures) during or immediately after an infusion.
B. The member is medically unstable (eg respiratory, cardiovascular, or renal conditions).
C. The member has severe venous access issues that require the use of a special interventions only available in the outpatient hospital setting.
D. The member has significant behavioral issues and/or physical or cognitive impairment that would impact the safety of the infusion therapy AND the patient does not have access to a caregiver.
E. Alternative infusion sites (pharmacy, physician office, ambulatory care, etc.) are greater than 30 miles from the member's home.
F. The member is less than 14 years of age.

For situations where administration of Cinryze does not meet the criteria for outpatient hospital infusion, coverage for Cinryze is provided when administered in alternative sites such as physician office, home infusion or ambulatory care.

II. REQUIRED DOCUMENTATION

The following information is necessary to initiate the site of care prior authorization review (where applicable):

A. Medical records supporting the member has experienced an adverse reaction that did not respond to conventional interventions or a severe adverse event during or immediately after an infusion

B. Medical records supporting the member is medically unstable
C. Medical records supporting the member has severe venous access issues that requires specialized interventions only available in the outpatient hospital setting
D. Medical records supporting the member has behavioral issues and/or physical or cognitive impairment and no access to a caregiver
E. Records supporting alternative infusion sites are greater than 30 miles from the member's home.
F. Medical records supporting the member is new to therapy

Section 2: Clinical Criteria

Specialty Guideline Management
Cinryze

Products Referenced by this Document

Drugs that are listed in the following table include both brand and generic and all dosage forms and strengths unless otherwise stated. Over-the-counter (OTC) products are not included unless otherwise stated.

Brand Name	Generic Name
Cinryze	C1 esterase inhibitor [human]

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 Indications[1]

Cinryze is indicated for routine prophylaxis against angioedema attacks in adults, adolescents and pediatric patients (6 years of age and older) with hereditary angioedema (HAE).

All other indications are considered experimental/investigational and not medically necessary.

Documentation

Submission of the following information is necessary to initiate the prior authorization review:

- For initial authorization, the following should be documented:

- C1 inhibitor functional and antigenic protein levels
- F12, angiopoietin-1, plasminogen, kininogen-1 (KNG1), heparan sulfate-glucosamine 3-O- sulfotransferase 6 (HS3ST6), or myoferlin (MYOF) gene mutation testing, if applicable
- Chart notes confirming family history of angioedema and the angioedema was refractory to a trial of high-dose antihistamine therapy, if applicable

- For continuation of therapy, chart notes demonstrating a reduction in frequency of attacks.

Prescriber Specialties

This medication must be prescribed by or in consultation with a prescriber who specializes in the management of HAE.

Coverage Criteria

Hereditary angioedema (HAE)[1-17]

Authorization of 12 months may be granted for prevention of hereditary angioedema attacks when the requested medication will not be used in combination with any other medication used for the prophylaxis of HAE attacks and both of the following criteria are met at the time of diagnosis:

Member meets either of the following criteria:
- Member has C1 inhibitor deficiency or dysfunction as confirmed by laboratory testing and meets one of the following criteria:
  - C1 inhibitor (C1-INH) antigenic level below the lower limit of normal as defined by the laboratory performing the test, or
  - Normal C1-INH antigenic level and a low C1-INH functional level (functional C1-INH less than 50% or C1-INH functional level below the lower limit of normal as defined by the laboratory performing the test).
- Member has normal C1 inhibitor as confirmed by laboratory testing and meets one of the following criteria:
  - Member has an F12, angiopoietin-1, plasminogen, kininogen-1 (KNG1), heparan sulfate-glucosamine 3-O-sulfotransferase 6 (HS3ST6), or myoferlin (MYOF) gene mutation as confirmed by genetic testing, or
  - Member has a documented family history of angioedema and the angioedema was refractory to a trial of high-dose antihistamine therapy (i.e., cetirizine at 40 mg per day or the equivalent) for at least one month.

Other causes of angioedema have been ruled out (e.g., angiotensin-converting enzyme inhibitor [ACE-I] induced angioedema, angioedema related to an estrogen-containing drug, allergic angioedema).

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Continuation of Therapy

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

- Member meets all requirements in the coverage criteria section.
- Member has experienced a significant reduction in frequency of attacks (e.g., ≥ 50%) since starting treatment.
- Member has reduced the use of medications to treat acute attacks since starting treatment.

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SECTION 2

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