

Haegarda® (C1 Esterase Inhibitor Subcutaneous [Human]) (Subcutaneous)

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I. Length of Authorization

Coverage will be provided for 12 months and may be renewed.

II. Dosing Limits

A. Quantity Limit (max daily dose) [NDC Unit]:

- Haegarda 2000 IU single-dose vial kit: 16 kits per 28 days
- Haegarda 3000 IU single-dose vial kit: 8 kits per 28 days

B. Max Units (per dose and over time) [HCPCS Unit]:

- 5,600 billable units per 28 days

III. Initial Approval Criteria ¹

Coverage is provided in the following conditions:

- For patients 12 years of age and older, patient must have tried and failed to respond to treatment with Takhzyro™ (lanadelumab-flyo) or a contraindication exists; **AND**
- Patient is at least 6 years of age; **AND**

Universal Criteria ^{1,13,18, 20}

- Must be prescribed by, or in consultation with, a specialist in: allergy, immunology, hematology, pulmonology, or medical genetics; **AND**
- Not used in combination with other prophylactic therapies targeting C1 inhibitor (i.e., Cinryze) or kallikrein (i.e., Takhzyro or Orladeyo); **AND**
- Confirmation the patient is avoiding the following possible triggers for HAE attacks:
 - Estrogen-containing oral contraceptive agents **AND** hormone replacement therapy; **AND**
 - Antihypertensive agents containing ACE inhibitors; **AND**
 - Dipeptidyl peptidase IV (DPP-IV) inhibitors (e.g., sitagliptin); **AND**

- Neprilysin inhibitors (e.g., sacubitril); **AND**

Prophylaxis to prevent Hereditary Angioedema (HAE) attacks † Φ 1,13,18,19,20

- Patient has a history of one of the following criteria for long-term HAE prophylaxis:
 - History of two (2) or more severe HAE attacks per month (i.e., airway swelling, debilitating cutaneous or gastrointestinal episodes)
 - Patient is disabled more than 5 days per month by HAE
 - History of at least one laryngeal attack caused by HAE; **AND**
- Treatment of patient with “on-demand” therapy (i.e., Kalbitor, Firazyr, Ruconest, or Berinert) did not provide satisfactory control or access to “on-demand therapy” is limited; **AND**
- Patient has one of the following clinical presentations consistent with a HAE subtype§, which must be confirmed by repeat blood testing (treatment for acute attack should not be delayed for confirmatory testing):

HAE I (C1-Inhibitor deficiency) §^{13,18,19,20}
<ul style="list-style-type: none"> • Low C1 inhibitor (C1-INH) antigenic level (C1-INH antigenic level below the lower limit of normal as defined by the laboratory performing the test); AND • Low C4 level (C4 below the lower limit of normal as defined by the laboratory performing the test); AND • Low C1-INH functional level (C1-INH functional level below the lower limit of normal as defined by the laboratory performing the test); AND <ul style="list-style-type: none"> ○ Patient has a family history of HAE; OR ○ Acquired angioedema has been ruled out (i.e., patient onset of symptoms occur prior to 30 years old, normal C1q levels, patient does not have underlying disease such as lymphoma or benign monoclonal gammopathy [MGUS], etc.)
HAE II (C1-Inhibitor dysfunction) §^{18,20}
<ul style="list-style-type: none"> • Normal to elevated C1-INH antigenic level; AND • Low C4 level (C4 below the lower limit of normal as defined by the laboratory performing the test); AND • Low C1-INH functional level (C1-INH functional level below the lower limit of normal as defined by the laboratory performing the test)
HAE with normal C1INH (formerly known as HAE III) §^{18,19}
<ul style="list-style-type: none"> • Prophylaxis for HAE with normal C1-INH is not routinely recommended and will be evaluated on a case by case basis <ul style="list-style-type: none"> ○ Prior to consideration of long-term prophylaxis, the patient must have demonstrated: <ul style="list-style-type: none"> ▪ An inadequate response or intolerance to an adequate trial of prophylactic therapy with an antifibrinolytic agent (e.g., tranexamic acid (TXA) or aminocaproic acid) and/or a 17α-alkylated androgen (e.g., danazol) unless contraindicated. Female patients may derive additional benefit from progestins^{15,16,17}; AND ▪ Response to therapy from an agent indicated for the treatment of acute attacks (i.e., C1 esterase inhibitor, icatibant, ecallantide, etc.)

† FDA Approved Indication(s); Φ Orphan Drug

IV. Renewal Criteria^{1,13,18,19,20}

Coverage can be renewed based upon the following criteria:

**HAEGARDA® (C1 Esterase Inhibitor Subcutaneous [Human])
Prior Auth Criteria**

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- Patient continues to meet the universal and other indication-specific relevant criteria identified in section III; **AND**
- Absence of unacceptable toxicity from the drug. Examples of unacceptable toxicity include the following: severe hypersensitivity reactions, thromboembolic events, etc.; **AND**
- Significant improvement in severity, frequency, and/or duration of attacks have been achieved and sustained

V. Dosage/Administration¹

Indication	Dose
Prophylaxis of Hereditary Angioedema (HAE) attacks	60 IU/kg body weight injected subcutaneously twice weekly (every 3 or 4 days) **Note: Patients may self-administer Haegarda after being instructed by their healthcare provider.

VI. Billing Code/Availability Information

HCPCS Code:

- J0599 – Injection, c-1 esterase inhibitor (human), (haegarda), 10 units; 1 billable unit = 10 IU

NDC(s):

- Haegarda 2000 IU single-dose vial kit: 63833-0828-xx
- Haegarda 3000 IU single-dose vial kit: 63833-0829-xx

VII. References

1. Haegarda [package insert]. Kankakee, IL; CSL Behring LLC; January 2022. Accessed August 2022.
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Appendix 1 – Covered Diagnosis Codes

ICD-10	ICD-10 Description
D84.1	Defects in the complement system

Appendix 2 – Centers for Medicare and Medicaid Services (CMS)

Medicare coverage for outpatient (Part B) drugs is outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals. In addition, National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) may exist and compliance with these policies is required where applicable. They can be found at:

<https://www.cms.gov/medicare-coverage-database/search.aspx>. Additional indications may be covered at the discretion of the health plan.

Medicare Part B Covered Diagnosis Codes (applicable to existing NCD/LCD/LCA): N/A

Medicare Part B Administrative Contractor (MAC) Jurisdictions		
Jurisdiction	Applicable State/US Territory	Contractor
E (1)	CA, HI, NV, AS, GU, CNMI	Noridian Healthcare Solutions, LLC
F (2 & 3)	AK, WA, OR, ID, ND, SD, MT, WY, UT, AZ	Noridian Healthcare Solutions, LLC
5	KS, NE, IA, MO	Wisconsin Physicians Service Insurance Corp
6	MN, WI, IL	National Government Services, Inc. (NGS)
H (4 & 7)	LA, AR, MS, TX, OK, CO, NM	Novitas Solutions, Inc.
8	MI, IN	Wisconsin Physicians Service Insurance Corp
N (9)	FL, PR, VI	First Coast Service Options, Inc.
J (10)	TN, GA, AL	Palmetto GBA, LLC
M (11)	NC, SC, WV, VA (excluding below)	Palmetto GBA, LLC
L (12)	DE, MD, PA, NJ, DC (includes Arlington & Fairfax counties and the city of Alexandria in VA)	Novitas Solutions, Inc.
K (13 & 14)	NY, CT, MA, RI, VT, ME, NH	National Government Services, Inc. (NGS)
15	KY, OH	CGS Administrators, LLC