Hereditary Angioedema (HAE), Treatment and Prophylaxis (for Ohio Only)

Policy Number: CSOH2025D0044.B
Effective Date: January 1, 2025

Instructions for Use

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Related Policies
None

Application

This Medical Benefit Drug Policy only applies to the state of Ohio. Any requests for services that are stated as unproven or services for which there is a coverage or quantity limit will be evaluated for medical necessity using Ohio Administrative Code 5160-1-01.

Coverage Rationale

This policy refers only to the following drug products:

- C1 Esterase Inhibitor (human):
  - Berinert® (for intravenous injection)
  - Cinryze® (for intravenous injection)
- C1 Esterase Inhibitor (recombinant):
  - Ruconest® (for intravenous injection)
- Plasma Kallikrein Inhibitor (human):
  - Kalbitor® (ecallantide, for subcutaneous injection)

Firazyr® (icatibant), Haegarda® [C1 esterase inhibitor (human)], and Takhzyro® (lanadelumab) are self-administered injections and obtained under the member's pharmacy benefit.

Berinert, Cinryze, and Kalbitor are considered medically necessary in certain circumstances. For medical necessity clinical coverage criteria, refer to the Ohio Department of Medicaid Unified Preferred Drug List Criteria.

Policy History/Revision Information

Date	Summary of Changes
04/01/2025	• Updated reference link to the *Ohio Department of Medicaid Unified Preferred Drug List Criteria* (no change to policy guidelines)
01/01/2025	**Coverage Rationale** ***Berinert, Cinryze, and Kalbitor*** • Replaced coverage guidelines with language to indicate Berinert, Cinryze, and Kalbitor are considered medically necessary in certain circumstances; for medical necessity clinical coverage criteria, refer to the *Ohio Department of Medicaid Unified Preferred Drug List Criteria* **Supporting Information** • Removed *Applicable Codes*, *Background*, *Clinical Evidence*, *FDA*, and *References* sections • Archived previous policy version CSOH2024D0044.A

Instructions for Use

This Medical Benefit Drug Policy provides assistance in interpreting UnitedHealthcare standard benefit plans. When deciding coverage, the federal, state (Ohio Administrative Code [OAC]), or contractual requirements for benefit plan coverage must be referenced as the terms of the federal, state (OAC), or contractual requirements for benefit plan coverage may differ from the standard benefit plan. In the event of a conflict, the federal, state (OAC), or contractual requirements for benefit plan coverage govern. Before using this policy, please check the federal, state (OAC), or contractual requirements for benefit plan coverage. UnitedHealthcare reserves the right to modify its Policies and Guidelines as necessary. This Medical Benefit Drug Policy is provided for informational purposes. It does not constitute medical advice.

UnitedHealthcare may also use tools developed by third parties, such as the InterQual® criteria, to assist us in administering health benefits. The UnitedHealthcare Medical Benefit Drug Policies are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.