Harvard Pilgrim Health Care | TUFTS Health Plan

Medical Necessity Guidelines
Medical Benefit Drugs

Cinryze® (C1 esterase inhibitor)

Effective: September 9, 2025

Guideline Type	☒ Prior Authorization ☐ Non-Formulary ☐ Step-Therapy ☐ Administrative

Applies to:

Commercial Products

☒ Harvard Pilgrim Health Care Commercial products; Fax 617-673-0988

☒ Tufts Health Plan Commercial products; Fax 617-673-0988

CareLink℠ – Refer to CareLink Procedures, Services and Items Requiring Prior Authorization

Public Plans Products

☒ Tufts Health Direct – A Massachusetts Qualified Health Plan (QHP) (a commercial product); Fax 617-673-0988

☐ Tufts Health Together – MassHealth MCO Plan and Accountable Care Partnership Plans; 617-673-0939

☒ Tufts Health RITogether – A Rhode Island Medicaid Plan; Fax 617-673-0939

☐ Tufts Health One Care* – A Medicare-Medicaid Plan (a dual eligible product); Fax 617-673-0956

*The MNG applies to Tufts Health One Care members unless a less restrictive LCD or NCD exists.

Senior Products

☐ Tufts Health Plan Senior Care Options (SCO), (a dual-eligible product); Fax 617-673-0956

☐ Tufts Medicare Preferred HMO, (a Medicare Advantage product); Fax 617-673-0956

☐ Tufts Medicare Preferred PPO, (a Medicare Advantage product); Fax 617-673-0956

Note: While you may not be the provider responsible for obtaining prior authorization, as a condition of payment you will need to ensure that prior authorization has been obtained.

Overview

Food and Drug Administration - Approved Indications

Cinryze (C1 esterase inhibitor) is a C1 esterase inhibitor indicated for routine prophylaxis against angioedema attacks in adults, adolescents, and pediatric patients (6 years of age and older) with Hereditary Angioedema (HAE).

Clinical Guideline Coverage Criteria

The plan may authorize Cinryze for Members when **ALL** of the following criteria are met:

Initial Authorization Criteria

1. Documented diagnosis of hereditary angioedema

AND

2. Prescribed by or in consultation with an allergist, hematologist, or immunologist

AND

3. Patient is at least 6 years of age or older

AND

4. Documentation that “on-demand” therapy (e.g., icatibant, Kalbitor, Ruconest, or Berinert) did not provide satisfactory control or access to “on-demand” therapy is limited

Reauthorization Criteria

1. The Member has a documented diagnosis of hereditary angioedema

AND

2. Prescribed by or in consultation with an allergist, hematologist, or immunologist

AND

3. Patient is at least 6 years of age or older

AND

4. Documentation of a positive clinical response as evidenced by **one (1)** of the following:

a. An improvement in severity and duration of attacks has been achieved and sustained
b. A decrease in attack frequency

Limitations

- Cinryze will be authorized for 12 months.
- Patients new to the plan stable on Cinryze should be reviewed against Initial Therapy coverage criteria.

Codes

The following code(s) require prior authorization:

Table 1: HCPCS Codes

HCPCS Codes	Description
J0598	Injection, C1 esterase inhibitor (human), 10 units

References

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3. Cinryze® (C1 Esterase Inhibitor [Human]) [package insert]. Exton, PA: ViroPharma Inc., November 2024.
4. Craig TJ, Levy RJ, Wasserman RL et al. Efficacy of human C1 esterase inhibitor concentrate compared with placebo in acute hereditary angioedema attacks. *J Allergy Clin Immunol*. Oct 2009;124(4):801-808.
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11. Lyseng-Williamson KA. Nanofiltered human C1 inhibitor concentrate (Cinryze®): in hereditary angioedema. *BioDrugs*. 2011 Oct 1;25(5):317-27.
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14. U.S. National Library of Medicine. Genetics Home Reference. Hereditary angioedema. URL: ghr.nlm.nih.gov/condition/hereditary-angioedema. Accessed 2013 April 10.
15. Weis M. Clinical review of hereditary angioedema: diagnosis and management. *Postgrad Med J* 2009; 121(6):113-20.
16. Zuraw B. Hereditary angioedema. *N Engl J Med*. 2008;359;1027-1036.
17. Zuraw BL, Busse PJ, White M et al. Nanofiltered C1 inhibitor concentrate for treatment of hereditary angioedema. *N Engl J Med*. 2010 Aug 5;363(6):513-22.
18. Zuraw BL, Kalfus I. Safety and efficacy of prophylactic nanofiltered C1-inhibitor in hereditary angioedema. *Am J Med*. 2012 Sep;125(9):938.e1-7.
19. Hereditary angioedema (due to C1 inhibitor deficiency): General care and long-term prophylaxis. UpToDate. Last updated January 19, 2021. Accessed online February 24, 2022 at https://www.uptodate.com/contents/hereditary-angioedema-due-to-c1-inhibitor-deficiency-general-care-and-long-term-prophylaxis?search=cinryze&source=search_result&selectedTitle=5~20&usage_type=default&display_rank=4.

Approval And Revision History

September 13, 2022: Reviewed by Pharmacy and Therapeutics Committee (P&T)

Subsequent endorsement date(s) and changes made:

- September 21, 2022: Reviewed by the Medical Policy Approval Committee (MPAC)
- October 10, 2023: No changes
- September 10, 2024: No changes
- July 2025: Administrative update to remove Harvard Pilgrim Health Care Stride Medicare Advantage from the Medical Necessity Guideline template.
- September 9, 2025: No changes.

Background, Product and Disclaimer Information

Medical Necessity Guidelines are developed to determine coverage for benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. We make coverage decisions using these guidelines, along with the Member's benefit document, and in coordination with the Member's physician(s) on a case-by-case basis considering the individual Member's health care needs.

Medical Necessity Guidelines are developed for selected therapeutic or diagnostic services found to be safe and proven effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in our service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. We revise and update Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Medical Necessity Guideline and a self-insured Member's benefit document, the provisions of the benefit document will govern. For Tufts Health Together (Medicaid), coverage may be available beyond these guidelines for pediatric members under age 21 under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefits of the plan in accordance with 130 CMR 450.140 and 130 CMR 447.000, and with prior authorization.

Treating providers are solely responsible for the medical advice and treatment of Members. The use of this guideline is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to eligibility and benefits on the date of service, coordination of benefits, referral/authorization, utilization management guidelines when applicable, and adherence to plan policies, plan procedures, and claims editing logic.