Pharmacy Medical Necessity Guidelines: Hereditary Angioedema Medications

Effective: May 1, 2026

Prior Authorization Required	√	Type of Review – Care Management	
Not Covered		Type of Review – Clinical Review	√
Pharmacy (RX) or Medical (MED) Benefit	RX	Department to Review	RXUM
These pharmacy medical necessity guidelines apply to the following: ☒ Tufts Health RITogether – A Rhode Island Medicaid Plan		**Fax Numbers:** RXUM: 617.673.0939	

Note: This guideline does not apply to Medicare Members (includes dual eligible Members).

OVERVIEW

FOOD AND DRUG ADMINISTRATION-APPROVED INDICATIONS

Andembry (garadacimab-gxii) is an activated Factor XII [FXIIa] inhibitor [monoclonal antibody]) indicated for prophylaxis to prevent attacks of hereditary angioedema (HAE) in adult and pediatric patients aged 12 years and older.

Dawnzera (donidalorsen) is a prekallikrein-directed antisense oligonucleotide indicated for prophylaxis to prevent attacks of HAE in adult and pediatric patients 12 years of age and older.

Haegarda (C1 Esterase Inhibitor [Human]) is a plasma-derived concentrate of C1 Esterase Inhibitor (Human) indicated for routine prophylaxis to prevent hereditary angioedema (HAE) attacks in patients 6 years of age and older.

Icatibant and Sajazir (icatibant) is a bradykinin B2 receptor antagonist indicated for the treatment of acute attacks of HAE in adults 18 years of age and older.

Orladeyo (berotralstat) is a plasma kallikrein inhibitor indicated for prophylaxis to prevent attacks of HAE. Orladeyo capsules are indicated for iadults and pediatric patients 12 years and older. Orladeyo oral pellets are indicated for pediatric patients 2 years to less than 12 years of age.

Takhzyro (lanadelumab-flyo) is a plasma kallikrein inhibitor (monoclonal antibody) indicated for prophylaxis to prevent attacks of HAE in adult and pediatric patients 2 years and older.

COVERAGE GUIDELINES

Haegarda (C1 Esterase Inhibitor [Human])

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

Initial Authorization Criteria

1. Documented diagnosis of hereditary angioedema

AND

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

AND

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

AND

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

Reauthorization Criteria

1. Documented diagnosis of hereditary angioedema

AND

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

AND

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

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

Icatibant, Sajazir (icatibant)
The plan may authorize coverage of icatibant or Sajazir for Members when **ALL** of the following criteria are met:
1. Documented diagnosis of hereditary angioedema

AND

2. Patient is at least 18 years of age or older

AND

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

Andembry (garadacimab-gxii), Dawnzera (donidalorsen), Orladeyo (berotralstat)
The plan may authorize coverage of Andembry, Dawnzera, Orladeyo for Members when **ALL** of the following criteria are met:
Initial Authorization Criteria
1. Documented diagnosis of hereditary angioedema

AND

2. Documentation of **ONE (1)** of the following:
    a. For Andembry, Dawnzera, Orladeyo capsule, patient is at least 12 years of age or older
    b. For Orladeyo oral pellet, patient is at least 2 years of age and less than 12 years of age

AND

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

AND

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

Reauthorization Criteria
1. Documented diagnosis of hereditary angioedema

AND

2. Documentation of **ONE (1)** of the following:
    a. For Andembry, Dawnzera, Orladeyo capsule, patient is at least 12 years of age or older
    b. For Orladeyo oral pellet, patient is at least 2 years of age and less than 12 years of age

AND

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

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

Takhzyro (lanadelumab-flyo)
The plan may authorize coverage of Takhzyro for Members when **ALL** of the following criteria are met:
Initial Authorization Criteria
1. Documented diagnosis of hereditary angioedema

AND

2. Patient is at least 2 years of age or older

AND

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

AND

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

Reauthorization Criteria
1. Documented diagnosis of hereditary angioedema

AND

2. Patient is at least 2 years of age or older

AND

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

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

AND

5. For patients who have been attack free for 12 months, provider attestation that consideration has been given to changing the patient to a dosing interval of 300 mg every four (4) weeks

LIMITATIONS

- Andembry, Dawnzera**,** Haegarda and Orladeyo will be authorized for 12 months.
- Takhzyro will be authorized for 6 months.
- Patients new to the plan stable on Andembry, Dawnzera, Haegarda, Orladeyo, or Takhzyro should be reviewed against Initial Therapy.
- The plan does not cover brand Firazyr. Refer to the Pharmacy Medical Necessity Guideline for Non-Formulary Exceptions.

CODES

None

REFERENCES

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APPROVAL HISTORY

September 13, 2022: Reviewed by Pharmacy & Therapeutics Committee.

- May 9, 2023: Updated approval duration and age requirements for Takhzyro (effective August 1, 2023).
- March 12, 2024: No changes
- January 14, 2025: For Icatibant and Sajazir, removed Documentation the patient has a history of at least one (1) severe attack within the past 6 months (eff 2/1/25).
- October 14, 2025: Added Andembry (garadacimab-gxii) to the Medical Necessity Guideline (eff 11/1/25).
- April 14, 2026: Added Orladeyo oral pellets and Dawnzera to the Medical Necessity Guideline (eff 5/1/26).

BACKGROUND, PRODUCT AND DISCLAIMER INFORMATION

Pharmacy Medical Necessity Guidelines have been developed for determining coverage for plan benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. The plan makes coverage decisions on a case-by-case basis considering the individual member's health care needs. Pharmacy Medical Necessity Guidelines are developed for selected therapeutic classes or drugs found to be safe, but proven to be 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 the service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. The plan revises and updates Pharmacy 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 Pharmacy Medical Necessity Guideline and a self-insured Member's benefit document, the provisions of the benefit document will govern.

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