

## 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 <sup>1</sup>

Coverage is provided in the following conditions:

- Patient is at least 6 years of age; **AND**

#### Universal Criteria <sup>1,13,18,20</sup>

- 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 <sup>1,13,18,19,20</sup>

- 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):

<b>HAE I (C1-Inhibitor deficiency) §<sup>13,18,19,20</sup></b>
<ul style="list-style-type: none"><li>• 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); <b>AND</b></li><li>• Low C4 level (C4 below the lower limit of normal as defined by the laboratory performing the test); <b>AND</b></li><li>• Low C1-INH functional level (C1-INH functional level below the lower limit of normal as defined by the laboratory performing the test); <b>AND</b><ul style="list-style-type: none"><li>○ Patient has a family history of HAE; <b>OR</b></li><li>○ 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.)</li></ul></li></ul>
<b>HAE II (C1-Inhibitor dysfunction) §<sup>18,20</sup></b>
<ul style="list-style-type: none"><li>• Normal to elevated C1-INH antigenic level; <b>AND</b></li><li>• Low C4 level (C4 below the lower limit of normal as defined by the laboratory performing the test); <b>AND</b></li><li>• Low C1-INH functional level (C1-INH functional level below the lower limit of normal as defined by the laboratory performing the test)</li></ul>
<b>HAE with normal C1INH (formerly known as HAE III) §<sup>18,19</sup></b>
<ul style="list-style-type: none"><li>• 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"><li>○ Prior to consideration of long-term prophylaxis, the patient must have demonstrated:<ul style="list-style-type: none"><li>▪ 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<sup>15,16,17</sup>; <b>AND</b></li><li>▪ Response to therapy from an agent indicated for the treatment of acute attacks (i.e., C1 esterase inhibitor, icatibant, ecallantide, etc.)</li></ul></li></ul></li></ul>

† FDA Approved Indication(s); Φ Orphan Drug

## IV. Renewal Criteria<sup>1,13,18,19,20</sup>

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/Administration<sup>1</sup>

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

## 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

## Nondiscrimination & Language Access Policy

Aspirus Health Plan, Inc. complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity. We do not exclude people or treat them differently because of race, color, national origin, age, disability, sex, sexual orientation, or gender identity.

We will:

Provide free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

Provide free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, contact us at the phone number shown on the inside cover of this contract, your id card, or aspirushealthplan.com.

If you believe that we have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity, you can file a grievance with:

Nondiscrimination Grievance Coordinator  
Aspirus Health Plan, Inc.  
PO Box 1062  
Minneapolis, MN 55440  
Phone: 1.866.631.5404 (TTY: 711)  
Fax: 763.847.4010  
Email: customerservice@aspirushealthplan.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Nondiscrimination Grievance Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services  
200 Independence Avenue, SW  
Room 509F, HHH Building  
Washington, D.C. 20201  
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

## Language Assistance Services

**Albanian:** KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1.866.631.5404 (TTY: 711).

**Arabic:** تنبيه: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية متاحة لك مجاناً. اتصل بن اعلی رقم الهاتف 1.866.631.5404 (رقم هاتف الصم والبك : 711)

**French:** ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelezle 1.866.631.5404 (ATS : 711).

**German:** ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1.866.631.5404 (TTY: 711).

**Hindi:** \_यान द\_ : य\_द आप िहंदी बोलते ह\_ तो आपके िलए मु\_त म\_ भाषा सहायता सेवाएं उपल\_ध ह\_। 1.866.631.5404 (TTY: 711) पर कॉल कर\_।

**Hmong:** LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1.866.631.5404 (TTY: 711).

**Korean:** 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1.866.631.5404 (TTY: 711)번으로 전화해 주십시오.

**Polish:** UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1.866.631.5404 (TTY: 711).

**Russian:** ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1.866.631.5404 (телетайп: 711).

**Spanish:** ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1.866.631.5404 (TTY: 711).

**Tagalog:** PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nangwalang bayad. Tumawag sa 1.866.631.5404 (TTY: 711)

**Traditional Chinese:** 注意: 如果您使用繁體中文, 您可以免費獲得語言援助服務。請致電 1.866.631.5404 (TTY: 711)。

**Vietnamese:** CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1.866.631.5404 (TTY: 711).

**Pennsylvania Dutch:** Wann du Deitsch (Pennsylvania German / Dutch) schwetzscht, kannscht du mitaus Koschte ebbergricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1.866.631.5404 (TTY: 711).

**Lao:** ໄປດຊາຍ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ 1.866.631.5404 (TTY: 711).