

UnitedHealthcare Pharmacy  
Clinical Pharmacy Programs

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|-------------------|--|
| Program Number    | 2018 P 1011-6  |
| Program           | Prior Authorization/Notification                         |
| Medication        | Berinert® (C1 esterase inhibitor, human)                 |
| P&T Approval Date | 11/2012, 11/2013, 8/2014, 8/2015, 7/2016, 7/2017, 7/2018 |
| Effective Date    | 10/1/2018;<br>Oxford only: 10/1/2018                     |

**1. Background:**

Berinert is a plasma-derived C1 esterase inhibitor (human) indicated for the treatment of acute abdominal, facial, or laryngeal attacks of hereditary angioedema (HAE) in adult and pediatric patients. The safety and efficacy of Berinert for prophylactic therapy has not been established.<sup>1</sup>

**2. Coverage Criteria:**

**A. Berinert** will be approved based on **all** of the following criteria:

1. Diagnosis of hereditary angioedema (HAE)

**-AND-**

2. For the treatment of acute HAE attacks

**-AND-**

3. Not used in combination with other approved treatments for acute HAE attacks (e.g. Firazyr, Kalbitor or Ruconest)

**Authorization of therapy will be issued for 12 months.**

**3. Additional Clinical Programs:**

- Supply limits may be in place.

**4. References:**

1. Berinert [package insert]. Kankakee, IL: CSL Behring LLC; September 2017.

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|-----------------------|---|
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| <b>Change Control</b> |   |
| 11/2013               | Annual review. Removed requirement for Type I or II HAE. Changed authorization duration from 12 months to 60 months.  |
| 8/2014                | Annual review. Added an additional criterion that does not allow combination use with other HAE acute treatments. Decreased authorization from 60 months to 12 months. Updated Background and References. |
| 8/2015                | Annual Review. Updated references.  |
| 7/2016                | Annual Review with no changes to the coverage criteria. Updated background and references.  |
| 7/2017                | Annual review with no changes to the coverage criteria. Updated background and references.  |
| 7/2018                | Annual review with no changes to the coverage criteria. Updated references.   |