

UnitedHealthcare Pharmacy  
Clinical Pharmacy Programs

Program Number	2021 P 2153-4
Program	Prior Authorization/Medical Necessity
Medication	Takhzyro™ (lanadelumab-flyo)
P&T Approval Date	11/2018, 11/2019, 6/2020, 3/2021
Effective Date	6/1/2021; Oxford only: 6/1/2021

**1. Background:**

Takhzyro is a plasma kallikrein inhibitor (monoclonal antibody) indicated for prophylaxis to prevent attacks of hereditary angioedema (HAE) in patients 12 years and older<sup>1</sup>.

**2. Coverage Criteria <sup>a</sup>:**

**A. Initial Authorization**

**1. Takhzyro will be approved based on all of the following criteria:**

a. Diagnosis of hereditary angioedema (HAE) as confirmed by **one** of the following:

- (1) C1 inhibitor (C1-INH) deficiency or dysfunction (Type I or II HAE) as documented by **one** of the following (per laboratory standard):
  - (a) C1-INH antigenic level below the lower limit of normal
  - (b) C1-INH functional level below the lower limit of normal

**-OR-**

- (2) HAE with normal C1 inhibitor levels and **one** of the following:
  - (a) Confirmed presence of a FXII, angiotensin-1, plasminogen gene mutation, or kininogen mutation
  - (b) Recurring angioedema attacks that are refractory to high-dose antihistamines with confirmed family history of angioedema

**-AND-**

b. **Both** of the following:

- (1) For prophylaxis against HAE attacks

**-AND-**

- (2) Not used in combination with other products indicated for prophylaxis

against HAE attacks (e.g., Cinryze, Haegarda, Orladeyo)

**-AND-**

c. **Both** of the following:

- (1) Prescriber attests that patient has experienced attacks of a severity and/or frequency such that they would clinically benefit from prophylactic therapy with Takhzyro.
- (2) Documentation of baseline HAE attack rate is greater than or equal to one attack per 4 weeks.

**-AND-**

d. Prescribed by **one** of the following:

- (1) Immunologist
- (2) Allergist

**Authorization of Takhzyro 300mg given every 2 weeks therapy will be issued for 8 months.**

**B. Reauthorization**

1. **Takhzyro** will be approved based on **all** of the following criteria:

- a. Documentation of positive clinical response, defined as a clinically significant reduction in the rate and/or number of HAE attacks, while on Takhzyro therapy

**-AND-**

- b. Reduction in the utilization of on-demand therapies used for acute attacks (e.g., Berinert, Ruconest, Firazyr, Kalbitor) as determined by claims information, while on Takhzyro therapy.

**-AND-**

c. Prescribed by **one** of the following:

- (1) Immunologist
- (2) Allergist

**-AND-**

d. **All** of the following:

(1) For prophylaxis against HAE attacks

**-AND-**

(2) Not used in combination with other products indicated for prophylaxis against HAE attacks (e.g., Cinryze, Haegarda, Orladeyo)

e. Documentation of the number of acute HAE attacks in the previous 6 months, while on Takhzyro therapy, therefore:

(1) Patient experienced no (zero) acute HAE attacks in the previous 6 months: **Authorization of Takhzyro 300mg given every 4 weeks for 12 months\***

(2) Patient experienced one or more acute HAE attacks in the previous 6 months: **Authorization of Takhzyro 300mg given every 2 weeks for 6 months**

\* Patients experiencing unexpected breakthrough HAE attacks once switched to every 4 week dosing will require additional review to allow for 2 weeks dosing.

<sup>a</sup> State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

### 3. Additional Clinical Programs:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply limits may be in place.

### 4. References:

1. Takhzyro [package insert]. Lexington, MA: Dyax Corp; November 2018.
2. Riedl MA, Bernstein JA, Craig T, et al. An open-label study to evaluate the long-term safety and efficacy of lanadelumab for prevention of attacks in hereditary angioedema: design of the HELP study extension. *Clin Transl Allergy*. 2017 Oct 6;7:36.
3. Maurer M, Magerl M, Ansotegui I, et al. The international WAO/EAACI guideline for the management of hereditary angioedema-The 2017 revision and update. *Allergy*. 2018 Jan 10.
4. Wu, E. Hereditary angioedema with normal C1 inhibitor. In: UpToDate, Saini, S (Ed), UpToDate, Waltham, MA, 2020.
5. Busse, P., Christiansen, S., Riedl, M., et. al. "US HAEA Medical Advisory Board 2020 Guidelines for the Management of Hereditary Angioedema." *The Journal of Allergy and Clinical Immunology*. 2020 September 05.

Program	Prior Authorization/Medical Necessity - Takhzyro™ (lanadelumab-flyo)
<b>Change Control</b>	
11/2018	New program.
11/2019	Annual review. Updated references.
6/2020	Align criteria with acute and prophylactic therapies.
3/2021	Added diagnosis criteria and aligned combination use language with prophylactic therapies. Updated references.