

**Berinert (C1 esterase inhibitor [human])**  
**Effective 01/01/2026**

<b>Plan</b>	<input type="checkbox"/> MassHealth UPPL <input checked="" type="checkbox"/> Commercial/Exchange	<b>Program Type</b>	<input checked="" type="checkbox"/> Prior Authorization <input type="checkbox"/> Quantity Limit <input type="checkbox"/> Step Therapy
<b>Benefit</b>	<input checked="" type="checkbox"/> Pharmacy Benefit <input type="checkbox"/> Medical Benefit		
<b>Specialty Limitations</b>	This medication has been designated specialty and must be filled at a contracted specialty pharmacy.		
<b>Contact Information</b>	<b>Medical Benefit</b> <b>Pharmacy Benefit</b>	Phone: 833-895-2611 Phone: 800-711-4555	Fax: 888-656-6671 Fax: 844-403-1029
<b>Exceptions</b>	N/A		

**Overview**
**FDA-Approved Indication**

Berinert is indicated for the treatment of acute abdominal, facial, or laryngeal hereditary angioedema (HAE) attacks in adult and pediatric patients.

**Compendial Use**

Short-term preprocedural prophylaxis for HAE attacks

**Coverage Guidelines**

Authorization may be granted for members new to the plan within the past 90 days who are currently receiving treatment with the requested medication, excluding when the product is obtained as samples or via manufacturer's patient assistance programs.

**OR**

Authorization may be granted for treatment of Hereditary Angioedema (HAE) when all the following criteria are met:

**Preprocedural Prophylaxis**

1. Member is using requested medication for preprocedural prophylaxis (i.e., prior to surgical or major dental procedures)
2. Documentation that the member has C1 inhibitor deficiency or dysfunction as confirmed by laboratory testing and meets ONE of the following criteria:
  - a. C1 inhibitor (C1-INH) antigenic level below the lower limit of normal as defined by the laboratory performing the test
  - b. Normal C1-INH antigenic level and a low C1-INH functional level (functional C1-INH less than 50% or C1-INH functional level below the lower limit of normal as defined by the laboratory performing the test).
3. Documentation that the member has normal C1 inhibitor as confirmed by laboratory testing and meets ONE of the following criteria:
  - a. Member has an F12, angiopoietin-1, plasminogen, kininogen-1 (KNG1), heparan sulfate-glucosamine 3-O-sulfotransferase 6 (HS3ST6), or myoferlin (MYOF) gene mutation as confirmed by genetic testing, or

- b. Member has a documented family history of angioedema and the angioedema was refractory to a trial of high-dose antihistamine therapy (i.e., cetirizine at 40 mg per day or the equivalent) for at least one month.
- 4. This medication is prescribed by or in consultation with a prescriber who specializes in the management of HAE.

#### **Acute Attacks**

- 1. The member is using requested medication for the treatment of acute HAE attacks
- 2. The requested medication will not be used in combination with any other medication used for the treatment of acute HAE attacks and either of the following criteria is met at the time of diagnosis:
- 3. Documentation that the member has C1 inhibitor deficiency or dysfunction as confirmed by laboratory testing and meets ONE of the following criteria:
  - a. C1 inhibitor (C1-INH) antigenic level below the lower limit of normal as defined by the laboratory performing the test, or
  - b. Normal C1-INH antigenic level and a low C1-INH functional level (functional C1-INH less than 50% or C1-INH functional level below the lower limit of normal as defined by the laboratory performing the test).
- 4. Documentation that the member has normal C1 inhibitor as confirmed by laboratory testing and meets ONE of the following criteria:
  - a. Member has an F12, angiopoietin-1, plasminogen, kininogen-1 (KNG1), heparan sulfate-glucosamine 3-O-sulfotransferase 6 (HS3ST6), or myoferlin (MYOF) gene mutation as confirmed by genetic testing, or
  - b. Member has a documented family history of angioedema and the angioedema was refractory to a trial of high-dose antihistamine therapy (i.e., cetirizine at 40 mg per day or the equivalent) for at least one month.
- 5. Member has had inadequate response, adverse reaction or contraindication to generic Firazyr (icatibant)
- 6. This medication is prescribed by or in consultation with a prescriber who specializes in the management of HAE.

#### **Continuation of Therapy**

Reauthorization will be granted for HAE when provider submits the following:

- 1. **Preprocedural Prophylaxis:** requesting authorization for continued short-term preprocedural prophylaxis (i.e., prior to surgical or major dental procedures) must meet all initial authorization criteria.
- 2. **Acute Attacks**
  - a. Member meets the criteria for initial approval.
  - b. Physician attestation that the member has experienced a reduction in severity and/or duration of acute attacks.
  - c. Prophylaxis should be considered based on the attack frequency, attack severity, comorbid conditions, and member's quality of life.

#### **Limitations**

- 1. Initial approvals will be granted for:
  - a. Preprocedural prophylaxis: 30 days
  - b. Acute Attacks: 6 months
- 2. Reauthorizations will be granted for:
  - a. Preprocedural prophylaxis: 30 days



b. Acute Attacks: 6 months

## References

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**Review History**

05/10/2023 – Created for May P&T; switched from CVS SGM to custom. Effective 7/1/23

10/08/2025 – Reviewed and Updated at October P&T. Updated policy to reflect it no longer applies to the medical benefit. Effective 01/01/2026.

