

**Policy #: 112**

**Original policy date: 9/1/09**  
**Revised date: 10/1/09**

**Page: 1 of 5**

**Title**

**Cinryze™ (C1 Inhibitor (Human))**

This medication is not covered by the pharmacy benefit. It is covered by the medical benefit or as a Home Infusion Therapy.

**Description**

**Cinryze™**, a C1 inhibitor replacement therapy, is indicated for routine prophylaxis against angioedema attacks in adolescent and adult patients with hereditary angioedema (HAE).

HAE is a relatively rare (1:10,000 to 1:50,000 prevalence) autosomal dominant disease caused by a deficiency of functionally active C1 inhibitor. It is estimated to impact about 6,000 to 10,000 individuals in the United States (US). The condition is characterized by recurrent episodes of nonpruritic, nonpitting subcutaneous or submucosal edema often involving the arms, legs, hands, feet, bowels, genitalia, trunk, face, tongue, or larynx. Symptoms generally commence in childhood (aged two to three years), worsening at puberty, and persist into adulthood, with the severity being unpredictable. Attacks in patients that are not treated occur every seven to 14 days on average; however, the frequency may range from no attacks to attacks occurring every three days. Patients with HAE have an increased frequency of autoimmune diseases, especially glomerulonephritis.

**When services are covered for Commercial products (excluding Medicare HMO Blue, Medicare PPO Blue, and Blue Medicare PFFS PlusRx plans; see below for coverage for these products)**

**Initial Authorization<sup>1</sup>:**

**We cover Cinryze™ (C1 Inhibitor (Human))** when all the following criteria have been met:

- A confirmed diagnosis of Hereditary Angioedema (HAE) (ICD-9 CM = 277.6)
  - Diagnosis made by an allergist, hematologist, or immunologist.
  - Confirmation of diagnosis with below normal C1-INH protein levels or function with consequent reduction of C4 level below normal, but with normal C1q levels.
- A history of severe HAE attacks with a frequency of at least twice per month for at least 6 months with symptoms involving extremities, trunk, oropharynx, or face. “Severe” is defined as events that significantly interrupt usual daily activity despite short term symptomatic treatment.
- Previous treatment failure or contraindication to one of the following long term prophylactic medications. Long term treatment failure is defined as treatment for at least 3 months with severe attacks continuing to occur at least twice per month or the occurrence of serious side effects):
  - danazol
  - stanozolol

**If the above criteria are met, the initial authorization will be approved for 6 months.**

**Re-Authorization<sup>1</sup>:**

**We cover Cinryze™ (C1 Inhibitor (Human))** when all the following criteria have been met:

- The patient has had 3 months of therapy
- There has been a decrease in the frequency and severity of HAE attacks while on therapy

**If the above criteria are met, the authorization will be approved for an additional 6 months.**

### **Short-Term Prophylaxis<sup>1</sup>:**

**We cover Cinryze™ (C1 Inhibitor (Human))** when all the following criteria have been met:

- A confirmed diagnosis of Hereditary Angioedema (HAE) (ICD-9 CM = 277.6)
  - Diagnosis made by an allergist, hematologist, or immunologist.
  - Confirmation of diagnosis with below normal C1-INH protein levels or function with consequent reduction of C4 level below normal, but with normal C1q levels.
- The patient will be undergoing dental or surgical procedures that put them at risk for a severe attack

**If the above criteria are met, the authorization will be approved for one treatment per procedure.**

### **When services are not covered for Commercial Products (excluding Medicare HMO Blue, Medicare PPO Blue, and Blue Medicare PFFS PlusRx products)**

We do not cover Cinryze for requests that do not meet the criteria above.

### **Individual consideration**

All our medical policies are written for the majority of people with a given condition. Each policy is based on medical science. For many of our medical policies, each individual's unique clinical circumstances may be considered in light of current scientific literature. For consideration of an individual patient, physicians may send relevant clinical information to:

Blue Cross Blue Shield of Massachusetts  
 Clinical Pharmacy Operations  
 25 Technology Place  
 Hingham, MA 02043  
 Tel: (800) 366-7778  
 Fax: (888) 641-5355

### **Managed care guidelines**

- Prior authorization is required for all out patient sites of service

### **Indemnity and PPO guidelines**

- Prior authorization **is** required when these medications are processed under the home infusion therapy benefit.
- Prior authorization **is not** required when these drugs are purchased by the physician and administered in the office in accordance with this medical policy.

### **Coding information**

*Procedure codes are from current CPT, HCPCS Level II, Revenue Code, and/or ICD-9-CM manuals, as recommended by the American Medical Association, Centers for Medicare and Medicaid Services and American Hospital Associations. Blue Cross Blue Shield Association national codes may be developed when appropriate.*

*The following codes are included below for informational purposes. Inclusion or exclusion of a code does not constitute or imply member coverage or provider reimbursement. Please refer to the member's contract*

*benefits in effect at the time of service to determine coverage or non-coverage as it applies to an individual member.*

**HCPCS codes:**

- C9249: injection, C1 esterase inhibitor (human), 10 units

**ICD-9 MC diagnosis code:**

- 277.6: other deficiencies of circulating enzymes

**Policy update history**

New Policy, effective 9/1/09. Policy updated 10/09 to reflect UM requirements.

**Footnotes**

<sup>1</sup>Based on the recommendations of the BCBSMA Pharmacy and Therapeutics Committee meeting on 5/12/09.

**References**

1. Cinryze™ [package insert] New York, NY: Lev Pharmaceuticals. Inc.; October 2008.
2. Zuraw B, Busse P, White M, et al. Efficacy and safety of long-term prophylaxis with C1 inhibitor (C1INH) concentrate in patients with hereditary angioedema (HAE) [abstract 1049]. *J Allergy Clin Immunol.* 2008;121(2 Suppl 1):S272.
3. Zuraw BL. Hereditary angioedema. *N Engl J Med.* 2008;359:1027-1036.
4. Bernstein JA. Hereditary angioedema: a current state-of-the-art review, VIII: current status of emerging therapies. *Ann Allergy Asthma Immunol.* 2008;100(Suppl 2):S41-S46.

This document is designed for informational purposes only and is not an authorization, or an explanation of benefits, or a contract. Receipt of benefits is subject to satisfaction of all terms and conditions of the coverage. Medical technology is constantly changing, and we reserve the right to review and update our policies periodically.

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**Home Infusion Therapy**  
Prior Authorization Form



Please complete and fax with the physician's prescription to: (888) 641-5355. If the patient is a BCBSMA employee, please fax the form to: (617)246-4013.

**FOR TPN THERAPY, USE MEDICAL POLICY #296 REQUEST FORM**

Company name:		Contact Name:	
Phone #:		Provider #:	
Fax#		Address:	
Patient name:		Address:	
Patient ID#:		DOB: ___/___/___	Diagnosis:
Prescribing Physician/addr:	_____	Telephone:	
PCP name/address:	_____	Telephone:	

Place of Service     Home     SNF     MD office     other (specify) \_\_\_\_\_

Primary Therapy

Primary drug name: \_\_\_\_\_      Approximate duration: \_\_\_/\_\_\_/\_\_\_ to \_\_\_/\_\_\_/\_\_\_

Dose: \_\_\_\_\_  
Frequency: \_\_\_\_\_      Route of Administration: \_\_\_\_\_      pump: Y N

Other Therapy

Other drug name: \_\_\_\_\_      Approximate duration: \_\_\_/\_\_\_/\_\_\_ to \_\_\_/\_\_\_/\_\_\_

Dose: \_\_\_\_\_  
Frequency: \_\_\_\_\_      Route of Administration: \_\_\_\_\_      pump: Y N

If this is a "drug only" authorization request, indicate other services the nursing agency is providing:

Nursing provided by: \_\_\_\_\_      Contact: \_\_\_\_\_  
Phone: \_\_\_\_\_      Fax: \_\_\_\_\_

Request for 7 Day Coverage : Date of occurrence: \_\_\_\_\_      request dates: \_\_\_\_\_  
Occurrence type:      Hospitalization      Death      Change of Therapy

**Physician signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**OR Copy of prescription REQUIRED with this request**



**Outpatient Medical Prior Authorization Form**

Please complete and fax to: (888) 641-5355

Please contact Pharmacy Operations with questions at (800) 366-7778

If the patient is a BCBSMA employee, please fax the form to: (617) 246-4013

<b>Servicing Provider</b>	<b>Name:</b> <b>NPI Number:</b>	<b>Requesting Provider</b>	<b>Name:</b> <b>NPI Number:</b>
<b>Phone#</b>		<b>Phone#</b>	
<b>Fax#</b>		<b>Fax#</b>	
<b>Contact Person:</b>		<b>Contact Person:</b>	
<b>Patient Name:</b>		<b>DOB</b> ___/___/___	<b>Diagnosis:</b>
<b>Patient BCBSMA ID#</b>			

**Drug/Therapy:**

Drug Name: \_\_\_\_\_ Dates of Service: \_\_\_/\_\_\_/\_\_\_ to \_\_\_/\_\_\_/\_\_\_

Dose: \_\_\_\_\_

Frequency: \_\_\_\_\_

**Additional Clinical (including previous treatment failure):**

Physician signature: \_\_\_\_\_ Date: \_\_\_\_\_