Pharmacy Medical Policy
Cinryze™ (C1 Inhibitor (Human))

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Policy Number: 112
BCBSA Reference Number: None

Related Policies
None

Policy
Commercial Members: Managed Care (HMO and POS), PPO, and Indemnity

Note: All requests for outpatient retail pharmacy for indications listed and not listed on the medical policy guidelines may be submitted to BCBSMA Clinical Pharmacy Operations by completing the Prior Authorization Form on the last page of this document. Physicians may also submit requests for exceptions via the web using Express PA which can be found on the BCBSMA provider portal or directly on the web at https://provider.express-path.com.

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

Initial Authorization
We cover Cinryze™ (C1 Inhibitor (Human)) when ALL the following criteria have been met:
- A confirmed diagnosis of Hereditary Angioedema (HAE)
  - 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**

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**

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

- A confirmed diagnosis of Hereditary Angioedema (HAE)
  - 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.

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

**CPT Codes / HCPCS Codes / ICD-9 Codes**

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. A draft of future ICD-10 Coding related to this document, as it might look today, is included below for your reference.

Providers should report all services using the most up-to-date industry-standard procedure, revenue, and diagnosis codes, including modifiers where applicable.

**CPT Codes**

There is no specific CPT code for this service.

<table>
<thead>
<tr>
<th>HCPCS codes:</th>
<th>Code Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>J0598</td>
<td>Injection, C-1 esterase inhibitor (human), Cinryze, 10 units</td>
</tr>
</tbody>
</table>

**Diagnosis coding**

<table>
<thead>
<tr>
<th>ICD-9-CM diagnosis codes:</th>
<th>Code Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>277.6</td>
<td>Other deficiencies of circulating enzymes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ICD-10 Diagnosis Codes</th>
</tr>
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<tbody>
<tr>
<td>D84.1</td>
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</table>
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. Physicians may send relevant clinical information for individual patients for consideration to:

Blue Cross Blue Shield of Massachusetts
Pharmacy Operations Department
25 Technology Place
Hingham, MA 02043
Tel: 1-800-366-7778
Fax: 1-800-583-6289

Managed Care Authorization Instructions
- Prior authorization is required for all out patient sites of service
- For all outpatient sites of service, physicians may fax or mail the attached form to the address above
- For all outpatient sites of service, physicians may also submit authorization requests via the web using Express PAth which can be found on the BCBSMA provider portal or directly on the web at https://provider.express-path.com

PPO and Indemnity Authorization Instructions
- Prior authorization is required when this medication is processed under the home infusion therapy benefit.
- Prior authorization is not required when this medication is purchased by the physician and administered in the office.
- Physicians may also fax or mail the attached form to the address above.
- Physicians may also submit authorization requests via the web using Express PAth which can be found on the BCBSMA provider portal or directly on the web at https://provider.express-path.com

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. 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.

Policy History
<table>
<thead>
<tr>
<th>Date</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>6/2017</td>
<td>Updated address for Pharmacy Operations.</td>
</tr>
<tr>
<td>7/2014</td>
<td>Updated Coding section with ICD10 procedure and diagnosis codes, effective 10/2015.</td>
</tr>
<tr>
<td>1/2014</td>
<td>Updated ExpressPAth language.</td>
</tr>
<tr>
<td>10/2009</td>
<td>Policy updated to reflect UM requirements.</td>
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</table>

References

Endnotes
1. Based on the recommendations of the BCBSMA Pharmacy and Therapeutics Committee meeting on 5/12/2009.

To request prior authorization using the Massachusetts Standard Form for Medication Prior Authorization Requests (eForm), click the link below:
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

<table>
<thead>
<tr>
<th>Company name:</th>
<th>Contact Name:</th>
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<tbody>
<tr>
<td>Phone #:</td>
<td>Provider #:</td>
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<tr>
<td>Fax#</td>
<td>Address:</td>
</tr>
<tr>
<td>Patient name:</td>
<td>Address:</td>
</tr>
<tr>
<td>Patient ID#:</td>
<td>DOB: <em><strong>/</strong></em>/_____</td>
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<tr>
<td>Prescribing Physician/addr:</td>
<td>Telephone:</td>
</tr>
<tr>
<td>PCP name/address:</td>
<td>Telephone:</td>
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Place of Service  ☐ Home  ☐ SNF  ☐ MD office  ☐ other (specify)

<table>
<thead>
<tr>
<th>Primary Therapy</th>
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<tbody>
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<td>Dose:</td>
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<td>Frequency:</td>
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<table>
<thead>
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<th>Other Therapy</th>
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<td>Other drug name:</td>
</tr>
<tr>
<td>Dose:</td>
</tr>
<tr>
<td>Frequency</td>
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</tbody>
</table>

☐ 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