AETNA BETTER HEALTH®
Coverage Policy/Guideline

Name:	Andembry	Page:	1 of 3
Effective Date:	9/17/2025	Last Review Date:	8/2025

Applies to:	☒Illinois	☐Florida	☐ Michigan
	☒New Jersey	☒Maryland	☒ Florida Kids
	☒Pennsylvania Kids	☐Virginia	☒Kentucky PRMD

Intent:

The intent of this policy/guideline is to provide information to the prescribing practitioner outlining the coverage criteria for Andembry under the patient's prescription drug benefit.

Description:

FDA-Approved Indication
Andembry is indicated for prophylaxis to prevent attacks of hereditary angioedema (HAE) in adult and pediatric patients aged 12 years and older.

All other indications are considered experimental/investigational and not medically necessary.

Applicable Drug List:

Andembry

Policy/Guideline:

Documentation

Submission of the following information is necessary to initiate the prior authorization review:

- Initial authorization:
  - C1 inhibitor functional and antigenic protein levels
  - F12, angiopoietin-1, plasminogen, kininogen-1 (KNG1), heparan sulfate-glucosamine 3-O-sulfotransferase 6 (HS3ST6), or myoferlin (MYOF) pathogenic variant testing, if applicable
  - Chart notes confirming family history of angioedema and the member's angioedema was refractory to a trial of high-dose antihistamine therapy, if applicable.
- Continuation of therapy, chart notes demonstrating a reduction in frequency of attacks.

Prescriber Specialties

This medication must be prescribed by or in consultation with a prescriber who specializes in the management of hereditary angioedema (HAE).

Coverage Criteria

Hereditary Angioedema (HAE)
Authorization of 12 months may be granted for prevention of hereditary angioedema attacks when the requested medication will NOT be used in combination with any other medication

used for the prophylaxis of HAE attacks and BOTH the following criteria are met at the time of diagnosis:

- Member meets EITHER of the following criteria:
  - Member has C1 inhibitor deficiency or dysfunction as confirmed by laboratory testing and meets ONE of the following criteria:
    - C1 inhibitor (C1-INH) antigenic level below the lower limit of normal as defined by the laboratory performing the test, or
    - 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).
- Member has normal C1 inhibitor as confirmed by laboratory testing and meets ONE of the following criteria:
  - Member has an F12, angiopoietin-1, plasminogen, kininogen-1 (KNG1), heparan sulfate-glucosamine 3-O-sulfotransferase 6 (HS3ST6), or myoferlin (MYOF) pathogenic variant as confirmed by genetic testing, or
  - Member has a documented family history of angioedema and the member's 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.
- Other causes of angioedema have been ruled out (e.g., angiotensin-converting enzyme inhibitor [ACE-I] induced angioedema, angioedema related to an estrogen-containing drug, allergic angioedema).
- Patient is unable to take the formulary alternatives Haegarda and Takhyzro for the given diagnosis due to a trial and inadequate treatment response or intolerance, or a contraindication.

Continuation of Therapy

Authorization of 12 months may be granted for continuation of therapy when ALL the following criteria are met:

- Member meets all requirements in the coverage criteria section.
- Member has experienced a significant reduction in frequency of attacks (e.g., ≥ 50%) since starting prophylactic treatment.
- Member has reduced the use of medications to treat acute attacks since starting prophylactic treatment.

Approval Duration and Quantity Restrictions:

Approval: 12 months

Quantity Level Limit:

Loading dose of 2 prefilled syringes or prefilled autoinjectors (200mg/1.2mL) for the first 30 days, followed by maintenance dose of 1 prefilled syringe or prefilled autoinjector (200mg/1.2mL) per 30 days.

References:

1. Andembry [package insert]. King of Prussia, PA: CSL Behring; June 2025.
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3. Henao MP, Kraschnewski J, Kelbel T, Craig T. Diagnosis and screening of patients with hereditary angioedema in primary care. Therapeutics and Clin Risk Management. 2016; 12: 701-711.
4. Bernstein, J. Severity of Hereditary Angioedema, Prevalence, and Diagnostic Considerations. Am J Med. 2018:24;292-298.
5. Busse PJ, Christiansen, SC, Riedl MA, et al. US HAEA Medical Advisory Board 2020 Guidelines for the Management of Hereditary Angioedema. J Allergy Clin Immunol: In Practice. 2021 Jan;9(1):132-150.e3.
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7. Kanani, A., Schellenberg, R. & Warrington, R. Urticaria and angioedema. All Asth Clin Immun 7, S9 (2011), Table 2.
8. Veronez CL, Csuka D, Sheik FR, et al. The expanding spectrum of mutations in hereditary angioedema. J Allergy Clin Immunol Pract. 2021;S2213-2198(21)00312-3