

	
AETNA BETTER HEALTH® Coverage Policy/Guideline	
Name: Takhzyro	Page: 1 of 3
Effective Date: 3/21/2025	Last Review Date: 2/2025
Applies to: <div style="display: flex; justify-content: space-between;"> <div> <input checked="" type="checkbox"/> Illinois <input type="checkbox"/> New Jersey <input checked="" type="checkbox"/> Pennsylvania Kids </div> <div> <input type="checkbox"/> Florida <input checked="" type="checkbox"/> Maryland <input type="checkbox"/> Virginia </div> <div> <input checked="" type="checkbox"/> Florida Kids <input type="checkbox"/> Michigan <input checked="" type="checkbox"/> Kentucky PRMD </div> </div>	

Intent:

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

Description:

The indications below including FDA-approved indications and compendial uses are considered a covered benefit provided that all the approval criteria are met and the member has no exclusions to the prescribed therapy.

FDA-Approved Indication

Takhzyro is indicated for prophylaxis to prevent attacks of hereditary angioedema (HAE) in adult and pediatric patients 12 years of age and older.

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

Applicable Drug List:

Takhzyro

Policy/Guideline:

Documentation:

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

- A. For initial authorization, the following should be documented:
 1. C1 inhibitor functional and antigenic protein levels
 2. F12, angiopoietin-1, plasminogen, kininogen-1 (KNG1), heparan sulfate-glucosamine 3-O-sulfotransferase 6 (HS3ST6), or myoferlin (MYOF) gene mutation testing, if applicable
 3. Chart notes confirming family history of angioedema and the angioedema was refractory to a trial of high-dose antihistamine therapy, if applicable
- B. For continuation of therapy, chart notes demonstrating a reduction in frequency of attacks

Prescriber Specialty:

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

	
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Criteria for Initial Approval:

Hereditary angioedema (HAE)

Authorization of 6 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 of the following criteria are met at the time of diagnosis:

- A. Member meets either of the following criteria:
 1. Member has C1 inhibitor deficiency or dysfunction as confirmed by laboratory testing and meets one of the following criteria:
 - i. C1 inhibitor (C1-INH) antigenic level below the lower limit of normal as defined by the laboratory performing the test, or
 - ii. 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).
 2. Member has normal C1 inhibitor as confirmed by laboratory testing and meets one of the following criteria:
 - i. 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
 - ii. 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.
- B. 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).

Continuation of Therapy:

Authorization of 6 months may be granted for continuation of therapy when all of the following criteria are met:

- A. Member meets the criteria for initial approval.
- B. Member has experienced a significant reduction in frequency of attacks (e.g., $\geq 50\%$) since starting treatment.
- C. Member has reduced the use of medications to treat acute attacks since starting treatment.
- D. The requested drug is being dosed every 4 weeks or dosing every 4 weeks has been considered if the member is well-controlled on therapy for more than 6 months.

Approval Duration and Quantity Restrictions:

Approval: 12 months



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Quantity Level Limit:

- Takhzyro (lanadelumab-flyo) 300 mg/2 mL (150mg/mL) single-dose vial: 2 vials per 28 days
- Takhzyro (lanadelumab-flyo) 300 mg/2 mL (150mg/mL) single-dose prefilled syringe: 2 syringes per 28 days
- Takhzyro (lanadelumab-flyo) 150 mg/mL singledose prefilled syringe: 2 syringes/vials per 28 days

References:

1. Takhzyro [package insert]. Lexington, MA: Dyax Corp., a Takeda company; February 2023.
2. Maurer M, Magerl M, Ansotegui I, et al. The international WAO/EAACI guideline for the management of hereditary angioedema – the 2021 revision and update. *Allergy*. 2022 Jan 10. doi: 10.1111/all. 15214. Online ahead of print.
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.
6. Sharma J, Jindal AK, Banday AZ, et al. Pathophysiology of Hereditary Angioedema (HAE) Beyond the SERPING1 Gene [published online ahead of print, 2021 Jan 14] [published correction appears in Clin Rev Allergy Immunol. 2021 Feb 17]. *Clin Rev Allergy Immunol*. 2021;10.1007/s12016-021-08835-8. Doi:10.1007/s12016-021-08835-8.
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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.