PHARMACY POLICY STATEMENT
Ohio Medicaid

<table>
<thead>
<tr>
<th>DRUG NAME</th>
<th>Ruconest (C1 esterase inhibitor (recombinant))</th>
</tr>
</thead>
<tbody>
<tr>
<td>BILLING CODE</td>
<td>J0596</td>
</tr>
<tr>
<td>BENEFIT TYPE</td>
<td>Medical</td>
</tr>
<tr>
<td>SITE OF SERVICE ALLOWED</td>
<td>Home/Office/Outpatient</td>
</tr>
<tr>
<td>STATUS</td>
<td>Prior Authorization Required</td>
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</tbody>
</table>

Ruconest is a C1 esterase inhibitor [recombinant] indicated for the treatment of acute attacks in adult and adolescent patients with hereditary angioedema (HAE).

HAE is a rare autosomal dominant disease characterized by episodic unpredictable swelling, which can occur in a variety of anatomic locations. The swelling results from excess production of the vasodilator bradykinin. Attacks may be painful and cause functional impairment but are not associated with pruritis. The most common types of HAE are caused by deficiency (type 1) or dysfunction (type 2) of C1 inhibitor (C1-INH). Type 1 is the most prevalent.

Ruconest (C1 esterase inhibitor (recombinant)) will be considered for coverage when the following criteria are met:

**Hereditary Angioedema (HAE)**

For **initial** authorization:
1. Member must be 12 years of age or older; AND
2. Medication must be prescribed by or in consultation with an allergist or immunologist; AND
3. Member has a diagnosis of HAE type I or type II confirmed by both of the following:
   a) Low C4 level;
   b) Low (<50% of normal) C1 inhibitor antigenic and/or functional level; AND
4. Medication is being prescribed for the treatment of acute HAE attacks; AND
5. Member has documented trial and failure of or contraindication to both icatibant (if 18 years of age or older) and Berinert; AND
6. Medication is not being used in combination with another acute HAE therapy (e.g., Berinert, Firazyr, Kalbitor); AND
7. Member does not have a history of allergy to rabbits or rabbit-derived products.
8. **Dosage allowed/Quantity limit:** 50 IU per kg IV; not to exceed 4200 IU (2 vials) per dose. May repeat 1 time; no more than 2 doses within 24 hours.
   QL: 8 vials per fill

*If all the above requirements are met, the medication will be approved for 6 months.*

For **reauthorization**:
1. Chart notes must document improvement such as faster time to symptom relief or resolution of attack.

*If all the above requirements are met, the medication will be approved for an additional 12 months.*
CareSource considers Ruconest (C1 esterase inhibitor (recombinant)) not medically necessary for the treatment of conditions that are not listed in this document. For any other indication, please refer to the Off-Label policy.

<table>
<thead>
<tr>
<th>DATE</th>
<th>ACTION/DESCRIPTION</th>
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<tbody>
<tr>
<td>08/28/2017</td>
<td>New policy for Ruconest created. Criteria for each type of HAE specified. Criteria of documentation of attacks, discontinuation of meds that can cause HAE, and restriction on combinations with other meds for acute attacks added.</td>
</tr>
<tr>
<td>07/01/2022</td>
<td>Transferred to new template. Updated references. Added pharmacy as benefit option. Replaced “Firazyr” to say “icatibant.” Changed age limit from 13 to 12.</td>
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</tbody>
</table>

References:


Effective date: 01/01/2023
Revised date: 07/01/2022