DIVISION OF HEALTH CARE FINANCING AND POLICY
NEVADA MEDICAID
DRUG USE REVIEW (DUR) BOARD
PROPOSED PRIOR AUTHORIZATION CRITERIA

Hereditary angioedema agents are a covered benefit of Nevada Medicaid for recipients who meet the following criteria for coverage.

1. Coverage and Limitations:
Authorization will be given if the following criteria are met and documented:

Requests for Cinryze® (C1 esterase inhibitor)

1. Must have ALL of the following:
   a. The recipient has a diagnosis of hereditary angioedema.
   AND
   The medication is being prescribed by or in consultation with an allergist or immunologist.
   AND
   The medication is being used as prophylaxis for hereditary angioedema attacks.
   AND
   The recipient has experienced an inadequate response or adverse event with an attenuated androgen (e.g. danazol, stanozolol) or antifibrinolytic (e.g., tranexamic acid, aminocaproic acid) agent or has a contraindication to all agents in these classes.
   AND
   The recipient routinely experiences more than one severe hereditary angioedema attack per month.
   OR
   The recipient has a history of laryngeal attacks.

Requests for Berinert® (C1 esterase inhibitor), Kalbitor® (ecallantide) and Firazyr® (icatibant)

1. Must have ALL of the following:
   a. The recipient has a diagnosis of hereditary angioedema.
   AND
   The medication is being prescribed by or in consultation with an allergist or immunologist.
   AND
   The medication is being used to treat acute hereditary angioedema attacks.

2. PA Guidelines:
Initial prior authorization approval will be for 6 months
Requests for continuation of therapy will be approved for 1 year

3. Quantity Limitations:
Cinryze® (C1 esterase inhibitor): 20 vials per 30 days
Kalbitor® (ecallantide): 6 vials per fill
Firazyr® (icatibant): 3 syringes per fill

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