UnitedHealthcare Pharmacy
Clinical Pharmacy Programs

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| Program Number | 2026 P 2211-7 |
| Program | Prior Authorization/Medical Necessity |
| Medication | Berinert® (C1 esterase inhibitor [human]) |
| P&T Approval Date | 6/2020, 4/2021, 4/2022, 4/2023, 4/2024, 4/2025, 4/2026 |
| Effective Date | 7/1/2026 |

**1. Background:**

Berinert is a plasma-derived C1 esterase inhibitor (human) indicated for the treatment of acute abdominal, facial, or laryngeal hereditary angioedema (HAE) attacks in adult and pediatric patients. The safety and efficacy of Berinert for prophylactic therapy have not been established.

**2. Coverage Criteria [a]:**

**A. Initial Authorization**

**1. Berinert** will be approved based on **all** of the following criteria:

a. Diagnosis of hereditary angioedema (HAE) as confirmed by **one** of the following:

(1) C1 inhibitor (C1-INH) deficiency or dysfunction (Type I or II HAE) as documented by **one** of the following (per laboratory standard):

(a) C1-INH antigenic level below the lower limit of normal
(b) C1-INH functional level below the lower limit of normal

**-OR-**

(2) HAE with normal C1 inhibitor levels and **one** of the following:

(a) Confirmed presence of variant(s) in the gene(s) for factor XII, angiopoietin-1, plasminogen-1, kininogen-1, myoferlin, or heparan sulfate-glucosamine 3-O-sulfotransferase 6
(b) Recurring angioedema attacks that are refractory to high-dose antihistamines with confirmed family history of angioedema
(c) Recurring angioedema attacks that are refractory to high-dose antihistamines with unknown background de-novo mutation(s) (i.e., no family history) (HAE-unknown)

**-AND-**

b. Prescribed for the acute treatment of HAE attacks

**-AND-**

c. Not used in combination with other products indicated for the acute treatment of HAE attacks (e.g., Ekterly, Firazyr, icatibant, Ruconest)

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**-AND-**

d. Submission of medical records documenting a history of failure, contraindication, or intolerance to Ruconest (C1 esterase inhibitor [recombinant])

**-AND-**

e. Prescribed by **one** of the following:

(1) Immunologist
(2) Allergist

**Authorization will be issued for 12 months.**

**B. Reauthorization**

1. **Berinert** will be approved based on **all** of the following criteria:

a. Documentation of positive clinical response to Berinert therapy

**-AND-**

b. Prescribed for the acute treatment of HAE attacks

**-AND-**

c. Not used in combination with other products indicated for the acute treatment of HAE attacks (e.g., Ekterly, Firazyr, icatibant, Ruconest)

**-AND-**

d. Prescribed by **one** of the following:

(1) Immunologist
(2) Allergist

**Authorization will be issued for 12 months.**

[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

**3. Additional Clinical Programs:**

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply limits may be in place.

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**4. References:**


1. Berinert [package insert]. Kankakee, IL: CSL Behring LLC; September 2021.
2. Maurer M, Magerl M, Ansotegui I, et al. The international WAO/EAACI guideline for the management of hereditary angioedema-The 2017 revision and update. Allergy. 2018 Jan 10.
3. Wu, E. Hereditary angioedema with normal C1 inhibitor. In: UpToDate, Saini, S (Ed), UpToDate, Waltham, MA, 2024.
4. Busse, P., Christiansen, S., Riedl, M., et. al. "US HAEA Medical Advisory Board 2020 Guidelines for the Management of Hereditary Angioedema." *The Journal of Allergy and Clinical Immunology.* 2020 September 05.
5. Maurer M, Magerl M, Betschel S, et al. The international WAO/EAACI guideline for the management of hereditary angioedema-The 2021 revision and update. Allergy. 2022;77(7):1961-1990. doi:10.1111/all.15214


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| **Change Control** | |
| 6/2020 | New program. |
| 4/2021 | Added diagnosis criteria. Updated references. |
| 4/2022 | Updated background to include the safety and efficacy for prophylactic use has not been established. Updated references. |
| 4/2023 | Annual review. Updated references. |
| 4/2024 | Annual review with update to examples of genetic variant(s) and diagnostic criteria with normal C1 inhibitor levels. Updated language for reauthorization criteria. |
| 4/2025 | Annual review. No changes to coverage criteria. |
| 4/2026 | Annual review. Added additional examples of acute HAE agents. |

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