

## Berinert® (C1 Esterase Inhibitor, Human) (Intravenous)

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### I. Length of Authorization

- Initial\*: Prior authorization validity will be provided initially for 12 weeks.
- Renewal\*: Prior authorization validity may be renewed every 12 weeks thereafter.

\*The cumulative amount of medication(s) the patient has on-hand, indicated for the acute treatment of HAE, will be taken into account when authorizing. The authorization will provide a sufficient quantity in order for the patient to have a cumulative amount of HAE medication(s) on-hand in order to treat up to 4 acute attacks per 4 weeks for the duration of the authorization.

### II. Dosing Limits

**Max Units (per dose and over time) [HCPCS Unit]:**

- 1000 billable units per 28 days

### III. Initial Approval Criteria <sup>1</sup>

Site of care specialty infusion program requirements are met (refer to [Moda Site of Care Policy](#)).

Coverage is provided in the following conditions:

- Patient has had a documented trial with inadequate response, intolerance or contraindication to the use of generic icatibant; **OR**
- Patient is less than 18 years of age

**Universal Criteria** <sup>1,13,20</sup>

- Must be prescribed by, or in consultation with, a specialist in allergy, immunology, hematology, pulmonology, or medical genetics; **AND**
- Will not be used in combination with another agent indicated for the treatment of acute attacks (i.e., Firazyr [icatibant], Kalbitor [ecallantide], Ruconest [C1 esterase inhibitor, recombinant]);  
**NOTE: Requests for combination duplicate therapy may be appropriate in some situations and will be reviewed on a case-by-case basis; AND**

- Confirmation the patient is avoiding the following possible triggers for HAE attacks:
  - Estrogen-containing oral contraceptive agents AND hormone replacement therapy; **AND**
  - Antihypertensive agents containing ACE inhibitors or angiotensin II receptor blockers (ARBs); **AND**
  - Dipeptidyl peptidase IV (DPP-IV) inhibitors (e.g., sitagliptin); **AND**
  - Neprilysin inhibitors (e.g., sacubitril); **AND**

#### **Treatment of acute abdominal, facial, or laryngeal attacks of Hereditary Angioedema (HAE) †**

Φ 1,13,20,21,22

- Patient has a history of moderate to severe cutaneous attacks (without concomitant urticaria) OR abdominal attacks OR mild to severe airway swelling attacks of HAE (i.e. debilitating cutaneous/gastrointestinal symptoms OR laryngeal/pharyngeal/tongue swelling); **AND**
- Patient has one of the following clinical presentations consistent with a HAE subtype§, which must be confirmed by repeat blood testing (treatment for acute attack should not be delayed for confirmatory testing):

<b>HAE I (C1-Inhibitor deficiency) § 13,20,21,22</b>
<ul style="list-style-type: none"> <li>• Low C1 inhibitor (C1-INH) antigenic level (C1-INH antigenic level below the lower limit of normal as defined by the laboratory performing the test); <b>AND</b></li> <li>• Low C4 level (C4 below the lower limit of normal as defined by the laboratory performing the test); <b>AND</b></li> <li>• Low C1-INH functional level (C1-INH functional level below the lower limit of normal as defined by the laboratory performing the test); <b>AND</b> <ul style="list-style-type: none"> <li>○ Patient has a family history of HAE; <b>OR</b></li> <li>○ Acquired angioedema has been ruled out (i.e., patient onset of symptoms occurs prior to 30 years of age, normal C1q levels, patient does not have underlying disease such as lymphoma or benign monoclonal gammopathy [MGUS], etc.)</li> </ul> </li> </ul>
<b>HAE II (C1-Inhibitor dysfunction) § 20,22</b>
<ul style="list-style-type: none"> <li>• Normal to elevated C1-INH antigenic level; <b>AND</b></li> <li>• Low C4 level (C4 below the lower limit of normal as defined by the laboratory performing the test); <b>AND</b></li> <li>• Low C1-INH functional level (C1-INH functional level below the lower limit of normal as defined by the laboratory performing the test)</li> </ul>

† FDA Approved Indication(s); § Compendia Recommended Indication(s); Φ Orphan Drug

## **IV. Renewal Criteria <sup>1</sup>**

Coverage can be renewed based upon the following criteria:

- Patient continues to meet the universal and other indication-specific relevant criteria identified in section III; **AND**
- Significant improvement in severity and duration of attacks has been achieved and sustained; **AND**
- Absence of unacceptable toxicity from the drug. Examples of unacceptable toxicity include: severe hypersensitivity reactions, serious thromboembolic events (arterial or venous), etc.; **AND**

- The cumulative amount of medication(s) the patient has on-hand, indicated for the acute treatment of HAE, will be taken into account when authorizing. The authorization will provide a sufficient quantity in order for the patient to have a cumulative amount of HAE medication(s) on-hand in order to treat up to 4 acute attacks per 4 weeks for the duration of the authorization.

## V. Dosage/Administration <sup>1</sup>

Indication	Dose
Treatment of Acute Hereditary Angioedema (HAE) attack	Administer 20 international units (IU) per kg body weight by intravenous injection. <b>**Note: Patients may self-administer Berinert upon recognition of symptoms of an HAE attack after being instructed by their healthcare provider.</b>

## VI. Billing Code/Availability Information

### HCPCS Code:

- J0597 – Injection, c-1 esterase inhibitor (human), berinert, 10 units; 1 billable unit = 10 units

### NDC:

- Berinert 500 IU single-dose carton kit (containing a single-dose vial of Berinert and a 10 mL vial of Sterile Water for Injection): 63833-0825-xx
- Berinert 500 IU single-dose vial: 63833-0835-xx

## VII. References

1. Berinert [package insert]. Kankakee, IL; CSL Behring LLC; September 2021. Accessed June 2025.
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## Appendix 1 – Covered Diagnosis Codes

ICD-10	ICD-10 Description
D84.1	Defects in the complement system

## Appendix 2 – Centers for Medicare and Medicaid Services (CMS)

The preceding information is intended for non-Medicare coverage determinations. Medicare coverage for outpatient (Part B) drugs is outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals. In addition, National Coverage Determinations (NCDs) and/or Local Coverage Determinations (LCDs) may exist and compliance with these policies is required where applicable. Local Coverage Articles (LCAs) may also exist for claims payment purposes or to clarify benefit eligibility under Part B for drugs which may be self-administered. The following link may be used to search for NCD, LCD, or LCA documents: <https://www.cms.gov/medicare-coverage-database/search.aspx>. Additional indications, including any preceding information, may be applied at the discretion of the health plan.

Medicare Part B Covered Diagnosis Codes (applicable to existing NCD/LCD/LCA): N/A

Medicare Part B Administrative Contractor (MAC) Jurisdictions		
Jurisdiction	Applicable State/US Territory	Contractor
E (1)	CA, HI, NV, AS, GU, CNMI	Noridian Healthcare Solutions, LLC
F (2 & 3)	AK, WA, OR, ID, ND, SD, MT, WY, UT, AZ	Noridian Healthcare Solutions, LLC
5	KS, NE, IA, MO	Wisconsin Physicians Service Insurance Corp (WPS)
6	MN, WI, IL	National Government Services, Inc. (NGS)
H (4 & 7)	LA, AR, MS, TX, OK, CO, NM	Novitas Solutions, Inc.
8	MI, IN	Wisconsin Physicians Service Insurance Corp (WPS)
N (9)	FL, PR, VI	First Coast Service Options, Inc.
J (10)	TN, GA, AL	Palmetto GBA
M (11)	NC, SC, WV, VA (excluding below)	Palmetto GBA
L (12)	DE, MD, PA, NJ, DC (includes Arlington & Fairfax counties and the city of Alexandria in VA)	Novitas Solutions, Inc.
K (13 & 14)	NY, CT, MA, RI, VT, ME, NH	National Government Services, Inc. (NGS)
15	KY, OH	CGS Administrators, LLC