Reference number(s)
2670-A

STANDARD MEDICARE PART B MANAGEMENT

TAKHZYRO (lanadelumab-flyo)

POLICY

I. INDICATIONS

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
Prophylaxis to prevent attacks of hereditary angioedema (HAE) in patients 12 years of age and older

All other indications will be assessed on an individual basis. Submissions for indications other than those enumerated in this policy should be accompanied by supporting evidence from Medicare approved compendia.

II. CRITERIA FOR INITIAL APPROVAL

Hereditary angioedema (HAE)
Authorization of 12 months may be granted for prevention of HAE attacks when either of the following criteria is met:
A. Member has C1 inhibitor deficiency or dysfunction as confirmed by laboratory testing.
B. Member has normal C1 inhibitor as confirmed by laboratory testing and meets one of the following criteria:
    1. Member has an F12, angiopoietin-1, plasminogen, or kininogen-1 (KNG1) gene mutation as confirmed by genetic testing.
    2. Member has a family history of angioedema and the angioedema was refractory to a trial of antihistamine (e.g., cetirizine) for at least one month.

III. CONTINUATION OF THERAPY

All members (including new members) requesting authorization for continuation of therapy must be currently receiving therapy with the requested agent.

Authorization of 12 months may be granted when all of the following criteria are met:
A. The member is currently receiving therapy with Takhzyro.
B. Takhzyro is being used to treat an indication enumerated in Section II.
C. The member is receiving benefit from therapy.

IV. REFERENCES

1. Takhzyro [package insert]. Lexington, MA: Dyax Corp.; November 2018.