Clinical Policy: Garadacimab-gxii (Andembry)

Reference Number: CP.PHAR.673
Effective Date: 06.16.25
Last Review Date: 11.25
Line of Business: Commercial, HIM, Medicaid

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Garadacimab-gxii (Andembry®) is a factor XIIa-inhibitory monoclonal antibody.

FDA Approved Indication(s)

Andembry is indicated as prophylaxis to prevent attacks of hereditary angioedema (HAE) in adult and pediatric patients aged 12 years and older.

Policy/Criteria

Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of health plans affiliated with Centene Corporation® that Andembry is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Hereditary Angioedema (must meet all)**:**

1. Diagnosis of HAE confirmed by both of the following (a and b):
   a. History of recurrent angioedema;
   b. Low C4 level and low C1-INH antigenic or functional level (*see Appendix D*);
2. Prescribed by or in consultation with a hematologist, allergist, or immunologist;
3. Age ≥ 12 years;
4. Prescribed for long-term prophylaxis of HAE attacks, and request meets one of the following (a, b, or c);
   a. Member experiences more than one severe event per month;
   b. Member is disabled more than five days per month;
   c. Member has a history of previous airway compromise;
5. Failure of one the following (a, b, or c)^, unless clinically significant adverse effects are experienced or all are contraindicated:*
   a. Haegarda®;
   b. Takhzyro®;
   c. Orladeyo®;

   ^Prior authorization may be required for Haegarda, Orladeyo, and Takhzyro
   **For Illinois HIM requests, the step therapy requirements above do not apply as of 1/1/2026 per IL HB 5395*
6. Member is not using Andembry in combination with another FDA-approved product for long-term prophylaxis of HAE attacks (e.g., Cinryze®, Haegarda®, Takhzyro®, Orladeyo®);

7. Dose does not exceed both of the following (a and b):
   a. Loading dose: 400 mg;
   b. Maintenance dose: 200 mg every month.

Approval duration:
Medicaid/HIM – 12 months
Commercial – 6 months or to the member's renewal date, whichever is longer

B. Other diagnoses/indications (must meet 1 or 2)**:**

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
   a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace, and CP.PMN.255 for Medicaid; or
   b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace, and CP.PMN.16 for Medicaid; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid.

II. Continued Therapy

A. Hereditary Angioedema (must meet all)**:**

1. Member meets one of the following (a or b):
   a. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
   b. Member is currently receiving medication and is enrolled in a state and product with continuity of care regulations (*refer to state specific addendums for CC.PHARM.03A and CC.PHARM.03B)*;
2. Member is responding positively to therapy as evidenced by a reduction in attacks from baseline;
3. Member is not using Andembry in combination with another FDA-approved product for long-term prophylaxis of HAE attacks (e.g., Cinryze, Haegarda, Takhzyro, Orladeyo);
4. If request is for a dose increase, new dose does not exceed 200 mg every month.*

Approval duration:
Medicaid/HIM – 12 months
Commercial – 12 months or to the member's renewal date, whichever is longer

B. Other diagnoses/indications (must meet 1 or 2)**:**
1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
   a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace, and CP.PMN.255 for Medicaid; or
   b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace, and CP.PMN.16 for Medicaid; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid.

III. Diagnoses/Indications for which coverage is NOT authorized:

A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policies – CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key
FDA: Food and Drug Administration
HAE: hereditary angioedema

Appendix B: Therapeutic Alternatives
This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may not be a formulary agent for all relevant lines of business and may require prior authorization.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
C1 esterase inhibitor (Haegarda)	60 IU/kg body weight SC twice weekly (every 3 or 4 days)	Based on weight, 60 IU/kg/dose
Orladeyo (berotralstat)	150 mg PO QD	150 mg/day
Takhzyro (lanadelumab-fylo)	300 mg SC every 2 weeks A dosing interval of 300 mg every 4 weeks may be considered if the patient is well-controlled (e.g., attack free) for more than 6 months	See dosing regimen

Therapeutic alternatives are listed as Brand name® (generic) when the drug is available by brand name only and generic (Brand name®) when the drug is available by both brand and generic.

Appendix C: Contraindications/Boxed Warnings
None reported

Appendix D: General Information
- Diagnosis of HAE:
  - There are two classifications of HAE: HAE with C1-INH deficiency (HAE-C1INH, further broken down into Type 1 and Type II) and HAE with normal C1-INH (also known as HAE-nl-C1INH). HAE-nl-C1INH was previously referred to as type III HAE, but this term is obsolete and should not be used.
  - In both Type I (~85% of cases) and Type II (~15% of cases), C4 levels are low. C1-INH antigenic levels are low in Type I while C1-INH functional levels are low in Type II. Diagnosis of Type I and II can be confirmed with laboratory tests. Reference ranges for C4 and C1-INH levels can vary across laboratories (see below for examples); low values confirming diagnosis are those which are below the lower end of normal.

Laboratory Test & Reference Range	Mayo Clinic	Quest Diagnostics	Lab Corp
C4	14 – 40 mg/dL	13-57 mg/dL (age- and gender-specific ranges)	10-38 mg/dL (age- and gender-specific ranges)
C1-INH, antigenic	19 – 37 mg/dL	21 – 39 mg/dL	21 – 39 mg/dL
C1-INH, functional	Normal: > 67% Equivocal: 41 – 67% Abnormal: < 41%	Normal: ≥ 68% Equivocal: 41 – 67% Abnormal: ≤ 40%	Normal: > 67% Equivocal: 41 – 67% Abnormal: < 41%

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
HAE attack prophylaxis	Loading dose of 400 mg as two 200 mg SC injections on Day 1, followed by a maintenance dosage of 200 mg SC every month thereafter	See dosing regimen

VI. Product Availability
- Single-dose prefilled syringe: 200 mg/1.2 mL
- Single-dose prefilled autoinjector: 200 mg/1.2 mL

VII. References
1. Andembry Prescribing Information. King of Prussia, PA: CSL Behring LLC; June 2025. Available at www.andembry.com. Accessed June 26, 2025.
2. Cicardi M, Bork K, Caballero T, et al. Evidence-based recommendations for the therapeutic management of angioedema owing to hereditary C1 inhibitor deficiency: consensus report of an International Working Group. *Allergy*. 2012; 67(2): 147-157.

3. Cicardi M, Aberer W, Banerji A, et al. Classification, diagnosis, and approach to treatment for angioedema: consensus report from the Hereditary Angioedema International Working Group. *Allergy*. 2014; 69(5): 602-616.
4. 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.
5. Busse PJ, Christiansen SC, Reidl MA, et al. US HAEA Medical Advisory Board 2020 Guidelines for the Management of Hereditary Angioedema. *J Allergy Clin Immunol.* 2021; 9(1): 132-150.e3.
6. Mayo Clinic Laboratories [internet database]. Rochester, Minnesota: Mayo Foundation for Medical Education and Research. Updated periodically. Accessed June 26, 2025.
7. Quest Diagnostics® [internet database]. Updated periodically. Accessed June 26, 2025.
8. LabCorp [internet database]. Burlington, North Carolina: Laboratory Corporation of America. Updated periodically. Accessed June 26, 2025.

Coding Implications
Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

HCPCS Codes	Description
C9399	Unclassified drugs or biologicals
J3590	Unclassified biologics

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created pre-emptively	02.19.24	05.24
2Q 2025 annual review: no significant changes as drug is not yet FDA-approved; references reviewed and updated.	02.14.25	05.25
RT4: drug is now FDA approved – criteria updated per FDA labeling; revised initial approval duration for Medicaid and HIM from 6 months to 12 months for this maintenance medication for a chronic condition; references reviewed and updated.	07.01.25	
Per August SDC, added redirection to one of the following: Haegarda, Takhzyro, or Orladeyo.	08.20.25	11.25

Important Reminder
This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in

developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions, and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment, or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members, and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note:
For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.