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Prior Authorization Guideline

Guideline Name	Dawnzera (donidalorsen)

Guideline Note:

Effective Date:	7/1/2026

1 . Criteria

Product Name:Dawnzera	
Approval Length	6 month(s)*
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of hereditary angioedema (HAE) confirmed by genetic testing or normal C1q lab levels with levels below the lab's normal reference range for both C4 and C1INH

AND

2 - Member has a history of attacks that are considered severe with swelling of the face, throat or gastrointestinal tract that significantly interrupts usual daily activity despite short-term symptomatic treatment

AND

3 - Member has been evaluated for triggers of HAE attacks and is maximally managed for avoidance of those triggers (such as stress, hormonal changes, dental surgery, trauma, medications including ACE inhibitors and estrogen)

AND

4 - Treatment with acute, abortive therapy is not an option for this member (Firazyr, Berinert)

AND

5 - Submission of medical records (e.g., chart notes) confirming trial and failure, intolerance or contraindication to Takzhyro

Notes	*All approvals subject to medical director review.

Product Name:Dawnzera	
Approval Length	6 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Member has been attack free for greater than 6 months

OR

2 - Both of the following:

2.1 There has been at least a 50% reduction in the number of angioedema attacks, significant improvement in the severity of attacks

AND

2.2 Submission of medical records (e.g., chart notes) confirming functional improvement