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Prior Authorization Guideline

Guideline Name	Andembry (garadacimab)

Guideline Note:

Effective Date:	7/1/2026

1 . Criteria

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

Approval Criteria

1 - The member has a diagnosis of hereditary angioedema (HAE) confirmed by one of the following:

1.1 C1-INH antigenic level below the lower limit of normal

OR

1.2 C1-INH functional level below the lower limit of normal

OR

1.3 Both of the following:

1.3.1 Normal C1-INH levels

AND

1.3.2 One of the following:

- Confirmed presence of variant(s) in the gene(s) for factor XII (F12), angiopoietin-1 (ANGPT1), plasminogen (PLG), kininogen-1 (KNG1), myoferlin (MYOF), and heparan sulfate-glucosamine 3-Osulfotransferase 6 (HS3ST6)
- Recurring angioedema attacks that are refractory to high-dose antihistamines

AND

2 - The 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 - The 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)

Product Name:Andembry

Approval Length	6 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - The patient has been attack free for greater than 6 months

OR

2 - There has been all of the following:

- At least a 50% reduction in the number of angioedema attacks
- Significant improvement in the severity of attacks
- Submission of medical records (e.g., chart notes) confirming functional improvement