UnitedHealthcare Pharmacy
Clinical Pharmacy Programs

Program Number	2025 P 1503-1
Program	Prior Authorization/Notification
Medication	Andembry® (garadacimab-gxii)
P&T Approval Date	11/2025
Effective Date	1/1/2026

1. Background:

Andembry is an activated Factor XII (FXIIa) inhibitor (monoclonal antibody) indicated for prophylaxis to prevent attacks of hereditary angioedema (HAE) in adult and pediatric patients aged 12 years and older.

2. Coverage Criteria[a]:

A. Andembry will be approved based on **all** of the following criteria:

1. Diagnosis of hereditary angioedema (HAE)

-AND-

2. Used for prophylaxis against HAE attacks

-AND-

3. Not used in combination with other products indicated for prophylaxis against HAE attacks (e.g., Cinryze, Dawnzera, Haegarda, Orladeyo, Takhzyro)

Authorization will be issued for 12 months.

[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3. Additional Clinical Programs:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply limits, Step Therapy, and/or Medical Necessity may be in place.

4. References:

1. Andembry [package insert]. King of Prussia, PA: CSL Behring LLC; June 2025.

Program	Prior Authorization/Notification – Andembry® (garadacimab-gxii)
Change Control	
11/2025	New program.