Louisiana Medicaid
Garadacimab-gxii (Andembry®)

The *Louisiana Uniform Prescription Drug Prior Authorization Form* should be utilized to request clinical authorization for garadacimab-gxii (Andembry®).

Additional Point-of-Sale edits may apply.

By submitting the authorization request, the prescriber attests to the conditions available HERE.

HAE Medication Use and Minimum Age per Current Drug-Specific Prescribing Information			
Medication	**Brand**	**Use**	**Minimum Age**
Garadacimab-gxii	Andembry®	Prophylaxis	12

Approval Criteria for Initiation of Therapy

- The recipient has a diagnosis of hereditary angioedema (HAE); **AND**
- The recipient's age on the date of the request is not less than the minimum age recommended in the prescribing information (see table); **AND**
- The requested medication is used as recommended in the prescribing information for either prevention or treatment (see table); **AND**
- The prescriber **states on the request** that the requested medication is not prescribed concurrently with another medication for HAE prophylaxis; **AND**
- There is no preferred alternative that is the exact same chemical entity, formulation, strength, etc. **AND**
- If the request is for a non-preferred agent - **ONE** of the following is required: (See Hereditary Angioedema on the PDL/NPDL for list of preferred agents)
    - The recipient has had a *treatment failure* with at least one preferred drug that is appropriate to use for the condition being treated; **OR**
    - The recipient has had an *intolerable side effect* to at least one preferred drug that is appropriate to use for the condition being treated; **OR**
    - The recipient has *documented contraindication(s)* to the preferred drugs that are appropriate to use for the condition being treated; **OR**
    - There is *no preferred product that is appropriate* to use for the condition being treated**.**

Approval Criteria for Continuation of Therapy

- The prescriber **states on the request** that the recipient is established on the medication with evidence of a positive response to therapy; **AND**
- The prescriber **states on the request** that the requested medication is not prescribed concurrently with another medication for HAE prophylaxis.

Duration of approval for initiation and continuation of therapy: 12 months

Reference

Andembry (garadacimab-gxii) [package insert]. King of Prussia, PA: CSL Behring LLC; June 2025. https://labeling.cslbehring.com/PI/US/Andembry/EN/Andembry-Prescribing-Information.pdf

Revision / Date	Implementation Date
Policy created / July 2025	January 2026