AETNA BETTER HEALTH®
Coverage Policy/Guideline

Name:	Rhapsido		Page: 1 of 2
Effective Date:	8/27/2026		Last Review Date: 1/2026
Applies to:	☒Illinois ☒New Jersey ☒Pennsylvania Kids	☐Florida ☒Maryland ☐Virginia	☒Florida Kids ☐Michigan ☐Kentucky PRMD

Intent:

The intent of this policy/guideline is to provide information to the prescribing practitioner outlining the coverage criteria for Rhapsido under the patient's prescription drug benefit.

Description:

FDA-approved Indications

Rhapsido is indicated for the treatment of chronic spontaneous urticaria (CSU) in adult patients who remain symptomatic despite H1 antihistamine treatment.

Limitations of Use
Rhapsido is not indicated for other forms of urticaria.

Applicable Drug List:

Non-preferred Agent:
Rhapsido

Policy/Guideline:

Coverage Criteria

Authorization may be granted when the requested drug is being prescribed for the treatment of chronic spontaneous urticaria (CSU) in an adult patient when ALL of the following criteria are met:

- The requested drug is being prescribed by or in consultation with an allergist, immunologist or dermatologist.
- The requested drug will NOT be used in combination with any other biologic or targeted synthetic drug for the same indication.
- The patient is unable to take Dupixent and Xolair, where indicated, for the given diagnosis due to a trial and inadequate treatment response or intolerance, or a contraindication. Documentation is required for approval.
- The patient has experienced a spontaneous onset of wheals (hives), angioedema, or both for at least 6 weeks.
- The patient has been evaluated for other causes of wheals (hives) and/or angioedema, including bradykinin-related angioedema and interleukin-1-associated urticarial syndromes (auto-inflammatory disorders, urticarial vasculitis).
- The patient remains symptomatic despite treatment with up-dosing (in accordance with EAACI/GA2LEN/EuroGuiDerm/APAAACI guidelines) of a second-generation H1

antihistamine (e.g., cetirizine, fexofenadine, levocetirizine, loratadine) for at least 2 weeks. [ACTION REQUIRED: Documentation is required for approval.]

Continuation of Therapy

Authorization may be granted when the requested drug is being prescribed for the treatment of chronic spontaneous urticaria (CSU) in an adult patient when ALL of the following criteria are met:

- The requested drug is being prescribed by or in consultation with an allergist, immunologist or dermatologist.
- The requested drug will NOT be used in combination with any other biologic or targeted synthetic drug for the same indication.
- The patient has experienced a positive clinical response (e.g., improved symptoms, decrease in weekly urticaria activity score [UAS7]) since initiation of therapy. [ACTION REQUIRED: Documentation is required for approval.]

Approval Duration and Quantity Restrictions:

Approval Duration:

- 12 months

Quantity Level Limit:

- 60 tablets every 30 days

References:

1. Rhapsido [package insert]. East Hanover, NJ: Novartis Pharmaceuticals Corporation.; September 2025.
2. Dupixent [package insert]. Tarrytown, NY: Regeneron Pharmaceuticals, Inc.; June 2025.
3. Xolair [package insert]. South San Francisco, CA: Genetech, Inc.; February 2024.
4. Lexicomp Online, Lexi-Drugs Online. Hudson, OH: UpToDate, Inc.; 2025; Accessed October 20, 2025.
5. Micromedex® (electronic version). Merative, Ann Arbor, Michigan, USA. Available at: https://www.micromedexsolutions.com/ (cited: 10/20/2025).
6. Zuberbier T, Abdul Latiff AH, Abuzakouk M, et al. The international EAACI/GA²LEN/EuroGuiDerm/APAAACI guideline for the definition, classification, diagnosis, and management of urticaria. Allergy. 2022 Mar;77(3):734-766.