ENHANCED SPECIALTY GUIDELINE MANAGEMENT

FIRAZYR (icatibant)

POLICY

I. INDICATIONS

The indications below including FDA-approved indications and compendial uses are considered a covered benefit provided that all the approval criteria are met and the member has no exclusions to the prescribed therapy.

FDA-Approved Indications
Treatment of acute attacks of hereditary angioedema in adults 18 years of age and older

All other indications are considered experimental/investigational and are not a covered benefit.

II. REQUIRED DOCUMENTATION

The following information is necessary to initiate the prior authorization review: C4 levels and C1 inhibitor functional and antigenic protein levels.

III. CRITERIA FOR INITIAL APPROVAL

Authorization of 12 months may be granted for the treatment of acute hereditary angioedema attacks in members 18 years of age or older when either of the following criteria is met:
1. Member has C1 inhibitor deficiency as confirmed by laboratory testing.
2. Member has normal C1 inhibitor as confirmed by laboratory testing and meets one of the following criteria:
   a. Member has an F12 gene mutation as confirmed by genetic testing, or
   b. Member has a family history of angioedema and the angioedema was refractory to a trial of antihistamine (e.g., cetirizine) for at least one month.

IV. CONTINUATION OF THERAPY

Authorization of 12 months may be granted for continuation of therapy when all of the following criteria are met:
1. Member meets the criteria for initial approval.
2. Member has experienced reduction in severity and duration of attacks since starting treatment.

V. REFERENCES

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