

PHARMACY POLICY STATEMENT

Ohio Medicaid

DRUG NAME	Firazyr or Sajazir (icatibant)
BILLING CODE	J1744
BENEFIT TYPE	Medical
SITE OF SERVICE ALLOWED	Home/Office
STATUS	Prior Authorization Required

Firazyr is a bradykinin B2 receptor antagonist indicated for treatment of acute attacks of hereditary angioedema (HAE) in adults 18 years of age and older.

HAE is a rare autosomal dominant disease characterized by episodic unpredictable swelling, which can occur in a variety of anatomic locations. The swelling results from excess production of the vasodilator bradykinin. Attacks may be painful and cause functional impairment but are not associated with pruritis. The most common types of HAE are caused by deficiency (type 1) or dysfunction (type 2) of C1 inhibitor (C1-INH). Type 1 is the most prevalent.

Firazyr is available as generic icatibant. Another brand name of icatibant is Sajazir.

Icatibant will be considered for coverage when the following criteria are met:

Hereditary Angioedema (HAE)

For **initial** authorization:

1. Member must be 18 years of age or older; AND
2. Medication must be prescribed by or in consultation with an allergist or immunologist; AND
3. Member has a diagnosis of HAE type I or type II confirmed by both of the following:
 - a) Low C4 level;
 - b) Low (<50% of normal) C1 inhibitor antigenic and/or functional level; AND
4. Medication is being prescribed for the treatment of acute HAE attacks; AND
5. Medication is not being used in combination with another on-demand therapy (e.g., Kalbitor, Berinert, Ruconest); AND
6. The member is not taking an ACE inhibitor; AND
7. If the request is for brand name Firazyr or Sajazir, documentation of medical necessity must be provided to justify inability to use generic icatibant.
8. **Dosage allowed/Quantity limit:** 30 mg subQ; may repeat at 6-hour intervals if response is inadequate. Max of 3 doses in 24 hours.
QL: 6 syringes per fill (18 mL)

If all the above requirements are met, the medication will be approved for 6 months.

For **reauthorization**:

1. Chart notes must document improvement such as faster time to symptom relief or resolution of attack.

If all the above requirements are met, the medication will be approved for an additional 12 months.



CareSource considers icatibant not medically necessary for the treatment of conditions that are not listed in this document. For any other indication, please refer to the Off-Label policy.

DATE	ACTION/DESCRIPTION
08/25/2017	