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.

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

B. Compendial Uses
Treatment of angiotensin-converting enzyme (ACE) inhibitor-induced angioedema

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

II. CRITERIA FOR INITIAL APPROVAL

A. Hereditary angioedema (HAE)
Indefinite authorization may be granted for the treatment of acute HAE 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.
   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.

B. ACE inhibitor-induced angioedema
Authorization of 3 days may be granted for acute management of ACE inhibitor-induced angioedema.

III. CONTINUATION OF THERAPY

All members (including new members) requesting authorization for continuation of therapy must meet all initial authorization criteria.

IV. REFERENCES

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