CareSource

PHARMACY POLICY STATEMENT
Arkansas PASSE

DRUG NAME	Firazyr (icatibant)
BILLING CODE	J1744
BENEFIT TYPE	Medical
SITE OF SERVICE ALLOWED	Home/Office
COVERAGE REQUIREMENTS	Prior-Authorization Required (Preferred Product) QUANTITY LIMIT— 6 syringes per fill (18 mL)
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Firazyr (icatibant) will only be considered for coverage under the **medical** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

HEREDITARY ANGIOEDEMA (HAE)

For **initial** authorization:

1. Member must be 18 years of age or older; AND
2. 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
3. Medication is being prescribed for the treatment of acute HAE attacks; AND
4. Medication is not being used in combination with another on-demand therapy (e.g. Kalbitor, Berinert, Ruconest); AND
5. The member is not taking an ACE inhibitor.
6. **Dosage allowed:** 30 mg subQ; may repeat at 6-hour intervals if response is inadequate. Max of 3 doses in 24 hours.

If member meets all the requirements listed above, 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 member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

CareSource considers Firazyr (icatibant) not medically necessary for the treatment of diseases that are not listed in this document.

DATE	ACTION/DESCRIPTION
08/25/2017	New policy for Firazyr created. Criteria for each type of HAE specified. Criteria of documentation of attacks, discontinuation of meds that can cause HAE, and restriction on combinations with other meds for acute attacks added.
01/20/2021	Updated references. Removed hematology as a specialist. Simplified the diagnostic criteria. Removed log book requirement. Removed statement about causative meds.

	Added ACE inhibitor interaction. Reworded renewal criteria. Extended initial auth duration to 6 mo and renewal to12 mo. Amended the quantity limit to say 6 syringes instead of 6 mL.
12/21/2021	Removed prescriber specialty requirement.

References:

1. Firazyr [package insert]. Lexington, MA: Takeda Pharmaceuticals America, Inc; 2020.
2. Frank MM, Zuraw B, Banerji A, et al. Management of children with hereditary angioedema due to C1 inhibitor deficiency. Pediatrics. 2016 Nov;138(5). pii: e20160575.
3. Busse PJ, Christiansen SC, Riedl MA, et al. US HAEA Medical Advisory Board 2020 Guidelines for the Management of Hereditary Angioedema [published online ahead of print, 2020 Sep 6]. *J Allergy Clin Immunol Pract*. 2020;S2213-2198(20)30878-3. doi:10.1016/j.jaip.2020.08.046
4. Maurer M, Magerl M, Ansotegui I, et al. The international WAO/EAACI guideline for the management of hereditary angioedema-The 2017 revision and update. *Allergy*. 2018;73(8):1575-1596. doi:10.1111/all.13384
5. Lumry WR, Farkas H, Moldovan D, et al. Icatibant for Multiple Hereditary Angioedema Attacks across the Controlled and Open-Label Extension Phases of FAST-3. *Int Arch Allergy Immunol*. 2015;168(1):44-55. doi:10.1159/000441060

Effective date: 01/01/2022
Revised date: 12/21/2021