UnitedHealthcare Community Plan

Clinical Pharmacy Program Guidelines for Firazyr

Program	Prior Authorization
Medication	Firazyr® (icatibant)
Issue Date	3/2013
Pharmacy and Therapeutics Approval Date	7/2017
Effective Date	9/2017

1. Background:

Firazyr® (icatibant) is a bradykinin B2 receptor antagonist indicated for treatment of acute attacks of hereditary angioedema (HAE) in adults 18 years of age and older.[1]

2. Coverage Criteria:

A. Firazyr will be approved based on **all** of the following criteria:

1. Diagnosis of hereditary angioedema (HAE)

-AND-

2. For the treatment of acute HAE attacks

-AND-

3. Not used in combination with other approved treatments for acute HAE attacks (e.g. Berinert, Kalbitor or Ruconest)

Authorization of therapy will be issued for 12 months.

3. References:

1. Firazyr [package insert]. Lexington, MA: Shire Orphan Therapies, Inc; December 2015.

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Program	Prior Authorization –Firazyr (icatibant)
Change Control	
Date	Change
3/2013	New pharmacy/medical guideline.
9/2014	Added “Not used in combination with other approved treatments for acute HAE attacks (eg, Berinert, Kalbitor or Ruconest).”
7/2016	Updated clinical criteria to align with Employer and Individual notification policy. Updated policy template.
7/2017	Annual review. No changes.

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