STATE OF WEST VIRGINIA
DEPARTMENT OF HEALTH AND HUMAN RESOURCES
BUREAU FOR MEDICAL SERVICES

Office of Pharmacy Service
Prior Authorization Criteria

FIRAZYR®
(icatibant)
Effective 12/16/2016

Prior Authorization Request Form

Firazyr is indicated for the treatment of acute attacks of hereditary angioedema (HAE)

Firazyr Criteria for Approval

1) The diagnosis of hereditary angioedema (HAE) must be clinically established by, or in consultation with, an allergist or immunologist; **AND**
2) Patient must be 18 years or older; **AND**
3) Diagnosis of HAE is documented based on evidence of low C4 level **AND** one of the following:
    a. A low C1 inhibitor (C1-INH) antigenic level; OR
    b. A normal C1-INH antigenic level and a low C1-INH functional level;

    AND
4) Patient is not concurrently taking an angiotensin converting enzyme (ACE) inhibitor or estrogen replacement therapy; **AND**
5) Patient must be experiencing at least one symptom of a moderate or severe attack (i.e. swelling of the face, throat, or abdomen).

Approvals are for 6 months

Continuation of Therapy Criteria:

Medical records documenting frequency of acute HAE attacks and the patient's response to therapy must be provided. If the patient is experiencing more than one acute HAE attack per month, medical records documenting use of a long-term prophylactic therapy (LTP) or the clinical rational for avoiding LTP must be provided.

References

1) Cinryze package insert 06/2016
2) Lexi-Comp Clinical Application 12/15/2016
3) UpToDate Articles accessed 12/16/16: Hereditary Angioedema and Pathogenesis; Hereditary Angioedema- General Care and Long-term Prophylaxis
4) US Hereditary Angioedema Association Medical Advisory Board 2013 Recommendations for the Management of Hereditary Angioedema Due to C1 Inhibitor Deficiency; J ALLERGY CLIN IMMUNOL: IN PRACTICE VOLUME 1, NUMBER 5

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