ICATIBANT

Generic	Brand	HICL	GCN	Exception/Other
ICATIBANT	FIRAZYR	35962		

***********Customer Service/PAC Alert************
(For Internal Use Only)

THIS IS A HIGH-IMPACT MEDICATION. DO NOT OVERRIDE OR APPROVE WITHOUT SUBMITTING FOR PHARMACIST REVIEW.

GUIDELINES FOR USE

1. Does the patient have a diagnosis of hereditary angioedema and meet ALL of the following criteria?
   - Diagnosis is confirmed via complement testing
   - The medication is being used for treatment of acute attacks of hereditary angioedema
   - The patient is 18 years of age or older
   - The medication is prescribed by or given in consultation with an allergist/immunologist or hematologist

   If yes, **approve for a duration of 12 months, each fill of #6 syringes (total of 18mL), up to 12 fills per year.**
   If no, do not approve.
   DENIAL TEXT: The guideline named **ICATIBANT (Firazyr)** requires a diagnosis of hereditary angioedema. In addition, all of the following criteria must be met:
   - Diagnosis is confirmed via complement testing
   - The medication is being used for treatment of acute attacks of hereditary angioedema
   - The patient is 18 years of age or older
   - The medication is prescribed by or given in consultation with an allergist/immunologist or hematologist

RATIONALE
Ensure appropriate use of Firazyr (icatibant) based on FDA approved indication and dosing.

FDA APPROVED INDICATION
Firazyr (icatibant) is indicated for the treatment of acute attacks of hereditary angioedema in adults 18 years of age and older.

CONTINUED ON NEXT PAGE

ICATIBANT

FDA APPROVED INDICATION (CONTINUED)

DOSING AND ADMINISTRATION

The recommended dose of Firazyr (icatibant) is 30 mg administered subcutaneously in the abdominal area. Additional doses may be administered at intervals of at least 6 hours if response is inadequate or if symptoms recur. No more than 3 doses may be administered in any 24-hour period (for a total of 90 mg). Patients may self-administer Firazyr (icatibant) upon recognition of symptoms of an HAE attack after training under the guidance of a healthcare professional.

REFERENCE

- Firazyr [Prescribing Information]. Lexington, MA: Shire Orphan Therapies; December 2015.

Library	Commercial	NSA
Yes	Yes	No

Part D Effective: N/A
Commercial Effective: 10/01/18
Created: 09/11
Client Approval: 09/18
P&T Approval: 07/18