GUIDELINES FOR USE

1. Does the patient have a diagnosis of hereditary angioedema (HAE) Type I or Type II as established by C1 inhibitor antigenic levels, C1 inhibitor functional levels AND C1q levels?
   
   If yes, continue to #2.
   If no, do not approve.
   **DENIAL TEXT:** See the denial text at the end of the guideline.

2. Is the patient 18 years of age or older?
   
   If yes, continue to #3.
   If no, do not approve.
   **DENIAL TEXT:** See the denial text at the end of the guideline.

3. Is the medication being prescribed (or patient overseen) by a hematologist or allergy/immunologist?
   
   If yes, continue to #4.
   If no, do not approve.
   **DENIAL TEXT:** See the denial text at the end of the guideline.

4. Does the patient have documented frequent (at least 1 per month) or severe (causing disability for at least 5 days or history of airway compromise) HAE attacks?
   
   If yes, approve for a duration of 12 months, each fill of #3 syringes (total of 9 mL), up to 12 fills per year.
   If no, do not approve.
   **DENIAL TEXT:** See the denial text at the end of the guideline.

**DENIAL TEXT:** Approval requires a diagnosis of hereditary angioedema Type I or Type II; documented age of 18 years old or older; medication being prescribed or patient overseen by hematologist or immunologist; documented frequent or severe HAE attacks.
RATIONALE
Ensure appropriate use of icatibant based on FDA approved indication and dosing.

The recommended dose of icatibant is 30 mg subcutaneously. Additional doses may be administered every 6 hours. No more than 3 doses in any 24 hour period for a total of 90 mg.

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

REFERENCE