Pharmacy Policy Bulletin

Title: Icatibant (Firazyr)

Policy #: Rx.01.109

Application of pharmacy policy is determined by benefits and contracts. Benefits may vary based on product line, group, or contract. Some medications may be subject to precertification, age, gender or quantity restrictions. Individual member benefits must be verified.

This pharmacy policy document describes the status of pharmaceutical information and/or technology at the time the document was developed. Since that time, new information relating to drug efficacy, interactions, contraindications, dosage, administration routes, safety, or FDA approval may have changed. This Pharmacy Policy will be regularly and updated as scientific and medical literature becomes available. This information may include new FDA-approved indications, withdrawals, or other FDA alerts. This type of information is relevant not only when considering whether this policy should be updated, but also when applying it to current requests for coverage.

Members are advised to use participating pharmacies in order to receive the highest level of benefits.

Intent:

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

The use of Icatibant (Firazyr) requires prior authorization (i.e. clinical pharmacy and/or Medical Director review).

Description:

Icatibant (Firazyr) inhibits bradykinin from binding the B2 receptor and thereby treats the clinical symptoms of an acute, episodic attack of hereditary angioedema.

Policy:

Icatibant (Firazyr) is approved when all of the following inclusion criteria are met:

- Documentation member is 18 years of age or older
- Documentation of a diagnosis of hereditary angioedema

Guidelines:

Refer to the specific manufacturer's prescribing information for administration and dosage details and any applicable Black Box warnings.

BENEFIT APPLICATION

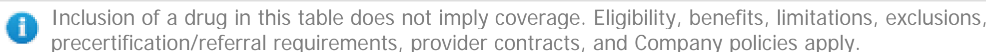
Subject to the terms and conditions of the applicable benefit contract, the applicable drug(s) identified in this policy is (are) covered under the pharmacy benefits of the Company's products when the medical necessity criteria listed in this pharmacy policy are met. Any services that are experimental/investigational or cosmetic are benefit contract exclusions for all products of the Company.

References:

Facts and comarisons website [Firazyr]. Available at www.factsandcomparisons.com. Accessed Novemer 11, 2011.

Firazyr [package insert]. Lexinton MA. Shire Orphan Therapuetics. 2011

Applicable Drugs:



Brand Name	Generic Name
Firazyr	icatibant

Cross References:

Policy Version Number: 1.00

P&T Approval Date: November 10, 2011

Policy Effective Date: February 01, 2012

Next Required Review Date: November 10, 2012

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