BlueCross BlueShield
Federal Employee Program

ICATIBANT
Firazyr **(icatibant)**
Sajazir (icatibant)
Preferred products: generic icatibant, Sajazir

Pre - PA Allowance
None

Prior-Approval Requirements

Age 18 years of age and older

Diagnosis

Patient must have the following:

1. Hereditary Angioedema (HAE) with **ONE** of the following:
    a. Patient has a C1 inhibitor deficiency or dysfunction as confirmed by laboratory testing **AND ALL** of the following:
        i. C4 level below the lower limit of normal as defined by the laboratory performing the test
        ii. C1 inhibitor (C1-INH) antigenic level below the lower limit of normal as defined by the laboratory performing the test **OR** normal C1-INH antigenic level and a low C1-INH functional level (functional C1-INH less than 50% or C1-INH functional level below the lower limit of normal as defined by the laboratory performing the test)
    b. Patient has normal C1 inhibitor as confirmed by laboratory testing **AND ONE** of the following:
        i. F12, angiopoietin-1, plasminogen, or kininogen-1 (KNG1) gene mutation as confirmed by genetic testing
        ii. Documented family history of angioedema and the angioedema was refractory to a trial of high-dose antihistamine (e.g., cetirizine) for at least one month

AND ALL of the following:
a. Used for acute attacks of hereditary angioedema
b. **NOT** being used for the routine prevention of hereditary angioedema attacks
c. **NO** dual therapy with another agent for treating acute attacks of hereditary angioedema (e.g., Berinert, Kalbitor, Ruconest)

ICATIBANT

Firazyr **(icatibant)**

Sajazir (icatibant)

Preferred products: generic icatibant, Sajazir

AND the following for Brand Firazyr **only:**

a. Patient **MUST** have tried at least **ONE** preferred product (generic Firazyr: icatibant or Sajazir) unless the patient has a valid medical exception (e.g., inadequate treatment response, intolerance, contraindication)

Prior - Approval Limits

Duration 12 months

Prior – Approval *Renewal* Requirements

Age 18 years of age and older

Diagnosis

The patient must have the following:

Hereditary Angioedema (HAE)

AND ALL of the following:

a. Used for acute attacks of hereditary angioedema
b. **NOT** being used for the routine prevention of hereditary angioedema attacks
c. Patient has experienced a reduction in severity and/or duration of hereditary angioedema attacks
d. **NO** dual therapy with another agent for treating acute attacks of hereditary angioedema (e.g., Berinert, Kalbitor, Ruconest)

AND the following for Brand Firazyr **only:**

a. Patient **MUST** have tried at least **ONE** preferred product (generic Firazyr: icatibant or Sajazir) unless the patient has a valid medical exception (e.g., inadequate treatment response, intolerance, contraindication)

Prior - Approval *Renewal* Limits

Same as above