CARE VALUE POLICY

POLICY: Hereditary Angioedema – Icatibant (Firazyr) Care Value Policy

• Firazyr® (icatibant subcutaneous injection – Takeda, generic)

REVIEW DATE: 08/25/2021

OVERVIEW

Icatibant (Firazyr, generic) is a synthetic decapeptide that is indicated for the **treatment of acute** hereditary angioedema (HAE) attacks in adults ≥ 18 years of age.¹

POLICY STATEMENT

This Care Value program has been developed to encourage the use of the Preferred Product. For Non-Preferred medications, the patient is required to meet the standard *Prior Authorization Policy* criteria. The program also directs the patient to try the Preferred Product prior to approval of the Non-Preferred Product. Requests for Non-Preferred Products will be reviewed using the exception criteria (below). All approvals are provided for the duration noted below. Of note, only Non-Preferred Products are required to undergo Prior Authorization.

<u>Documentation</u>: Documentation will be required where noted in the criteria as [documentation required]. Documentation may include, but is not limited to, chart notes, prescription claims records, and prescription receipts.

Automation: None.

Preferred Product: generic icatibant

Non-Preferred Product: Firazyr

RECOMMENDED EXCEPTION CRITERIA

Non-Preferred Product	Exception
Firazyr	1. Approve for 1 year if the patient meets ALL of the following (A, B, and C):
	A) Patient meets the standard <i>Hereditary Angioedema – Icatibant (Firazyr)</i>
	Prior Authorization Policy criteria; AND
	B) Patient has tried generic icatibant [documentation required]; AND
	C) The Brand product is being requested due to a formulation difference in the
	inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent,
	and/or surfactant] between the Brand and the bioequivalent generic product
	which, per the prescriber, would result in a significant allergy or serious
	adverse reaction [documentation required].

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REFERENCES

1. Firazyr® [prescribing information]. Lexington, MA: Takeda; August 2020.