PREFERRED SPECIALTY MANAGEMENT POLICY

POLICY: Hereditary Angioedema – Icatibant Preferred Specialty Management Policy
- Firazyr® (icatibant subcutaneous injection – Takeda, generic)
- Sajazir™ (icatibant subcutaneous injection – Cycle)

REVIEW DATE: 09/21/2022

OVERVIEW

Icatibant is a synthetic decapeptide that is indicated for the **treatment of acute hereditary angioedema (HAE) attacks** in adults ≥ 18 years of age.[1,2]

POLICY STATEMENT

This Preferred Specialty Management program has been developed to encourage the use of a Preferred Product. For all medications (Preferred and Non-Preferred), the patient is required to meet the respective standard *Prior Authorization Policy* criteria. The program also directs the patient to try one Preferred Product prior to the approval of the Non-Preferred Product. Requests for Non-Preferred Products will also be reviewed using the exception criteria (below). If the patient meets the standard *Hereditary Angioedema – Icatibant Prior Authorization Policy* criteria but has not tried the Preferred Product, approval for the Preferred Products will be authorized. All approvals are for 1 year in duration, unless otherwise noted below.

Documentation: 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, Sajazir
Non-Preferred Product: Firazyr

RECOMMENDED EXCEPTION CRITERIA

Non-Preferred Product	Exception Criteria
Firazyr	**1.** Approve for 1 year if the patient meets ALL of the following (A, B, and C): **A)** Patient meets the standard *Hereditary Angioedema – Icatibant Prior Authorization Policy* criteria; AND **B)** Patient has tried one of generic icatibant or Sajazir **[documentation required]**; AND **C)** Patient cannot continue to use the Preferred medication due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**. **2.** If the patient has met the standard *Hereditary Angioedema – Icatibant Prior Authorization Policy* criteria (1A) but has not met exception criteria (1B) and/or (1C): approve generic icatibant and Sajazir.

REFERENCES

1. Firazyr® [prescribing information]. Lexington, MA: Takeda; October 2021.
2. Sajazir™ subcutaneous injection [prescribing information]. Cambridge, UK: Cycle; June 2021.