UnitedHealthcare Pharmacy
Clinical Pharmacy Programs

Program Number	2023 P 1032-11
Program	Prior Authorization/Notification
Medications	Firazyr® (icatibant), Sajazir™ (icatibant)
P&T Approval Date	11/2011, 11/2012, 11/2013, 8/2014, 8/2015, 7/2016, 7/2017, 7/2018, 7/2019, 7/2020, 7/2021, 7/2022, 4/2023
Effective Date	7/1/2023; Oxford only: N/A

1. Background:

Firazyr (icatibant) is a bradykinin B2 receptor antagonist indicated for treatment of acute attacks of hereditary angioedema (HAE) in adults 18 years of age and older.[1] Sajazir (icatibant) injection is a bradykinin B2 receptor antagonist indicated for treatment of acute attacks of HAE in adults 18 years of age and older.[2]

2. Coverage Criteria[a]:

A. Firazyr or **Sajazir** will be approved based on **all** of the following criteria:

1. Diagnosis of hereditary angioedema (HAE)

-AND-

2. For the treatment of acute HAE attacks

-AND-

3. Not used in combination with other approved treatments for acute HAE attacks (e.g., Berinert, Kalbitor or Ruconest)

Authorization will be issued for 12 months.

[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3. Additional Clinical Programs:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply limits may be in place.

4. References:

1. Firazyr [package insert]. Lexington, MA: Takeda Pharmaceuticals America, Inc.; October 2021.
2. Sajazir [package insert]. Cambridge, CB3 0FA, United Kingdom: Cycle Pharmaceuticals Ltd; May 2022.

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Change Control	
11/2013	Annual review. Removed requirement for Type I or II HAE. Changed authorization duration from 12 months to 60 months.
8/2014	Annual review. Added an additional criterion that does not allow combination use with other HAE acute treatments. Decreased authorization from 60 months to 12 months. Updated Background and References.
8/2015	Annual review. No change.
7/2016	Annual review with no changes to the clinical criteria. Updated background and references.
7/2017	Annual review. No changes to program.
7/2018	Annual review. No changes to program.
7/2019	Annual review. No changes to program.
7/2020	Annual review. No changes to coverage criteria.
7/2021	Annual review. No changes to coverage criteria. Reference updated.
7/2022	Annual review with no changes to coverage criteria. Added state mandate footnote. Updated reference.
4/2023	Added Sajazir, updated background, and updated references.