

UnitedHealthcare Pharmacy  
Clinical Pharmacy Programs

Program Number	2025 P 2209-7
Program	Prior Authorization/Medical Necessity
Medication	Firazyr® (icatibant)*, icatibant, Sajazir™ (icatibant)*
P&T Approval Date	6/2020, 4/2021, 4/2022, 4/2023, 2/2024, 4/2024, 4/2025
Effective Date	7/1/2025

## 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. 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. Coverage Criteria <sup>a</sup>:

### A. Initial Authorization

1. **Firazyr\***, **icatibant**, or **Sajazir\*** will be approved based on **all** of the following criteria:

a. Diagnosis of hereditary angioedema (HAE) as confirmed by **one** of the following:

(1) C1 inhibitor (C1-INH) deficiency or dysfunction (Type I or II HAE) as documented by **one** of the following (per laboratory standard):

- (a) C1-INH antigenic level below the lower limit of normal
- (b) C1-INH functional level below the lower limit of normal

**-OR-**

(2) HAE with normal C1 inhibitor levels and **one** of the following:

- (a) Confirmed presence of variant(s) in the gene(s) for factor XII, angiotensin-converting enzyme 1, plasminogen-1, kininogen-1, myoferlin, or heparan sulfate-glucosaminase 3-O-sulfotransferase 6
- (b) Recurring angioedema attacks that are refractory to high-dose antihistamines with confirmed family history of angioedema
- (c) Recurring angioedema attacks that are refractory to high-dose antihistamines with unknown background de-novo mutation(s) (i.e., no family history) (HAE-unknown)

**-AND-**

b. **Both** of the following:

(1) Prescribed for the acute treatment of HAE attacks

**-AND-**

- (2) Not used in combination with other products indicated for the acute treatment of HAE attacks (e.g., Berinert, Kalbitor, or Ruconest)

-AND-

- c. Prescribed by **one** of the following:

- (1) Immunologist
- (2) Allergist

**Authorization of therapy will be issued for 12 months.**

**B. Reauthorization**

1. **Firazyr\***, **icatibant**, or **Sajazir\*** will be approved based on **all** of the following criteria:

- a. Documentation of positive clinical response to icatibant therapy

-AND-

- b. **Both** of the following:

- (1) Prescribed for the acute treatment of HAE attacks

-AND-

- (2) Not used in combination with other products indicated for the acute treatment of HAE attacks (e.g., Berinert, Kalbitor, or Ruconest)

-AND-

- c. Prescribed by **one** of the following:

- (1) Immunologist
- (2) Allergist

**Authorization of therapy will be issued for 12 months.**

<sup>a</sup> 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.

\* Firazyr (brand) and Sajazir are typically excluded from coverage. Coverage reviews may be in place if required by law or the benefit plan.

**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: Shire Orphan Therapies, LLC; January 2024.
2. Maurer M, Magerl M, Ansotegui I, et al. The international WAO/EAACI guideline for the management of hereditary angioedema-The 2017 revision and update. *Allergy*. 2018 Jan 10.
3. Wu, E. Hereditary angioedema with normal C1 inhibitor. In: UpToDate, Saini, S (Ed), UpToDate, Waltham, MA, 2023.
4. Busse, P., Christiansen, S., Riedl, M., et. al. "US HAEA Medical Advisory Board 2020 Guidelines for the Management of Hereditary Angioedema." *The Journal of Allergy and Clinical Immunology*. 2020 September 05.
5. Maurer M, Magerl M, Betschel S, et al. The international WAO/EAACI guideline for the management of hereditary angioedema-The 2021 revision and update. *Allergy*. 2022;77(7):1961-1990. doi:10.1111/all.15214
6. Sajazir [package insert]. Cambridge, CB3 0FA, United Kingdom: Cycle Pharmaceuticals Ltd; February 2024.

Program	Prior Authorization/Medical Necessity - Firazyr (icatibant), Sajazir (icatibant)
Change Control	
6/2020	New program.
4/2021	Added diagnosis criteria. Updated references.
4/2022	Updated references.
4/2023	Annual review. Added Sajazir, updated background, and updated references.
2/2024	Added coverage exclusion statement for brand Firazyr and Sajazir. Added Kalbitor to list of other products indicated for the acute treatment of HAE attacks.
4/2024	Update to examples of genetic variant(s) and diagnostic criteria with normal C1 inhibitor levels. Updated language for reauthorization criteria. Updated references.
4/2025	Annual review. No changes to coverage criteria. Updated reference.